Primecare Support Limited

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Inspection report

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Date of inspection visit:
19 April 2022
29 April 2022

Date of publication:
06 March 2024

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Prime Care Support Limited is a domiciliary care agency providing personal care to people in their own homes, some of whom may live with dementia. At the time of the inspection, 205 people were receiving the regulated activity of personal care.

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

People's experience of using this service and what we found
People were not always protected from the risk of abuse. Care visits were planned with a variable approach, opposed to agreed contractual times. People were at risk of harm due to unsafe medicines management and oversight.

Risks to people were not always identified, nor reassessed, following initial assessment, change in health or following an incident. Infection control procedures were not robust. People considered vulnerable to COVID-19 had not had individual risk assessments completed following our last inspection. Staff were not being supported to follow government guidance for COVID-19 testing. The provider continued to experience staffing difficulties and told us this was due to the pandemic. We found safe recruitment procedures took place, however, a repeat of checks was not completed during employment to ensure staff remained suitable for their roles.

We have made a recommendation for the provider to consider developing policies and risk assessments in relation to ongoing staff safety checks.

Staff training provision had been reviewed; however, not all staff had completed specific training in topics related to people's needs. The provider had systems and processes in place to ensure the needs of people were assessed, however, we found these were not always followed. Care plans were task focused opposed to detailing the individual needs and preferences of people. People were supported to access healthcare support and appointments. People were supported with meals and drinks, where it was part of their care package. Staff took action to help ensure people had food and drinks available between care visits. However, the risks of leaving food at room temperature had not been explored with people.

We have made a recommendation for the provider to consult with people to consider risk reducing measures where food is left at room temperature for a period of time.

People did not always feel included in all aspects of their care, including the planning and knowledge of care visit timings. People told us this impacted negatively on their day to day lives.

People's care plans were not personalised and did not evidence thorough assessments which promoted independence. People and relatives knew how to raise a complaint or concern, however, many lacked confidence in the provider's procedures.

Continued failings were present at this inspection and the provider remained in breach of all regulations identified at the last inspection. The registered manager and provider lacked oversight in key areas which placed people at risk of harm. Clear and effective quality assurance systems were not embedded at the service. We received mixed feedback from people, relatives and staff regarding their communication experiences with the registered manager, provider and office staff. Furthermore, the provider had failed to ensure the locations CQC rating was available to the public.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us visiting staff were caring and supportive. Visiting care staff respected people's privacy and dignity and were discreet and respectful to the needs of people. People told us information was provided to them in a way which met their communication needs.

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 inadequate (published 01 November 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified continued breaches in relation to protecting people from abuse; staffing; safe care and treatment and good governance at this inspection. We have identified a new breach in relation to person-centred care 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.

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

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 continue to monitor information we receive about the service, which will help inform when we next inspect. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains 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 of 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 well-led. Details are in our well-led findings below.	**Inadequate**

Prime Care Support Limited

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 Health and Social Care Act 2008.

Inspection team
This 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.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We announced this inspection activity on 22 March 2022. We gave the service 48 hours' notice of the visit to the location's office. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 March 2022 and ended on 29 April 2022. We visited the location's office on 19 April 2022.

What we did before the inspection

We reviewed the information we had received about the service since the last inspection. We sought feedback from local authorities and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 15 people who used the service and eight relatives about their experience of the care provided. We spoke with 21 members of staff including the registered manager, business manager and the nominated individual. The nominated individual is also the provider, and therefore responsible for supervising the management of the service.

We reviewed a range of records relating to staff. This included recruitment documentation, induction records, training and supervision records. We also viewed care records for fourteen people. Records reviewed included care plans, risk assessments, monitoring documentation, medication and care visit records. Additionally, we reviewed quality monitoring documents, policies and other records relating to the management and oversight of the service.

We held video calls with the registered manager and nominated individual in addition to our visit to their location's office.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained 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; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure systems and processes were followed when harm had occurred. Lessons were not learnt to reduce the likelihood of harm reoccurring. This was a breach of regulation 13 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 13.

- Systems and processes were not robust to protect people from abuse. Staff had received safeguarding training, however, some incidents where potential abuse took place were not recognised and reported.
- The provider had failed to identify and respond to neglectful practices which had placed people at risk of harm. For example, one person had not received enough time between their doses of strong pain relief. This had placed the person at risk of overdose and poor pain control. Another person, due to variable planned care visits, was administered their sleep aid medicine earlier than prescribed. The safety of this person had not been considered, which had increased their risk of incidents, such as falls.
- Additionally, during this inspection, we identified a person used their care call line which had summoned emergency services. Due to ineffective documentation and practices, it was not clear if this was due to error, or due to a late call time which may have caused distress to the person. The registered manager was not aware of this incident, and we were therefore not confident in reporting practices and oversight. We notified the local authorities of safeguarding concerns for three people which were identified at the time of this inspection.

Systems and oversight had not been robustly established in all areas to protect people from potential abuse. People were still at risk of harm. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings, people told us they felt safe with staff. One person told us, "Yes, (I) feel safe. [Staff] are very caring." Another person said, "Yes, I feel safe, [staff] check on me twice a day."
- Staff logging in and out of care visits had improved, and reviews had taken place with staff.

Staffing and recruitment

At our last inspection the provider had failed to ensure people were supported by sufficient numbers of staff. This was a breach of regulation 18 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 18.

● People were at risk due to variable call times. People's care visits were not scheduled for their agreed times. Whilst care visit timings appeared to meet satisfactory targets, we found these were changed without consultation with people. This not only had an impact upon people but did not evidence robust oversight. The provider continued to experience difficulties recruiting staff, and the COVID-19 pandemic had caused additional staffing pressures.
● People were not always confident when to expect staff to arrive. One person told us, "[The] morning visit is usually on time, but the evening visit could be anywhere between 4 and 7pm, I have to be patient." Another person said, "The visits are all over the place, they can be different every day, my body clock is all over the place. It doesn't help me get a routine going." A further person told us, "My lunchtime calls are all over the place, they are supposed to be here at 12.30pm, but they could come anytime between 12 and 2.30pm."
● Care visit timing variances were found across the records we viewed for people. For example, a care visit had taken place for a person at 05:59am when their agreed care visit time was 07:30am. We found this call had been scheduled for 06:00am. No explanation was available as to why the visit time did not reflect the agreed contractual time for the person. The provider told us a member of staff had changed the planned visit times for people on a routine basis, and they had not been aware. However, we found similar examples at our last two inspections.
● Staff told us they experienced pressure to meet care visit times. Staff said time allocated for travel between people was often minimal, and there was not always time to take a sufficient break. One staff member told us, "[It is like being] thrust pillar to post." At the time of our office visit, a member of staff spoke with the registered manager about their workload, and inability to meet critical scheduled call times. The registered manager did respond to the staff member, and their schedule was reviewed.
● Staff said they often had additional calls placed on their schedule which made it difficult to meet expectations. One staff member told us, "[Service] feels so short staffed, firefighting all the time." Care visit recorded times were often shorter than the contracted call duration, and daily records did not indicate a reason or if this was the person's preference. The registered manager was unable to provide insight as to why this occurred and had continued to accept new packages of care. This was evidence of a continued ineffective system in place to monitor calls as found at our last inspection.

There were not enough staff to meet the needs of people. People experienced variable planned call times which were not reflective of their contractual agreements. People were at risk of harm due to inadequate staff availability. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Not all people told us they experienced problems with their care visit times. One person told us, "Yes it's fine, they come on time. They ring if running late." A relative told us, "It's pretty good. They let us know if running late. They stay for the length of the call."
● The provider undertook specific checks when recruiting staff, however, Disclosure and Barring Service (DBS) checks were not reapplied for on a routine or timed basis to ensure the continued safety of people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions. Four staff had not had a criminal record check completed since 2004, another staff member had not had one completed since 2005. The provider did not have a risk assessment or policy surrounding this. However, staff were required by the provider to complete annual declarations to share any change to their original DBS status.

We recommend the provider considers reviewing and developing their recruitment procedures to include DBS timescales for staff.

Using medicines safely

At our last inspection the provider had failed to ensure staff administered and managed people's medicines safely. This was a breach of regulation 12 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.

● Medicine processes were not safe. People did not always receive their medicines at the correct time, and oversight was not effective nor robust. Staff did not have the appropriate knowledge to determine administration times for some medicines, and advice was not sought from the prescriber.
● Following our last inspection, the provider reviewed critical care call times for some people, however, did not include all people and their needs. For example, we found the review had not been expanded to include people who were prescribed strong pain relief, or medicine to aid sleep. This resulted in people receiving their medicines at inappropriate times. Additionally, critical call times had not been explored for one person with epilepsy during their initial assessment. This meant the person's timed medicine requirement had not been considered. The variable call visit times did not consider people's health needs in relation to their medicines. This had placed people at risk of harm.
● Medicine administration records (MAR) were developed by 'care assessors'. Visiting care staff took a photo of prescribed medicine labels and sent this to the office for the MAR to be created. We found this process did not allow for robust review of medicine packets and patient information leaflets contained within. We found people had not been administered their medicines as prescribed, and medicines were given to people earlier or later than the optimal times.
● The providers oversight of medicines had failed to identify the concerns we found. Monthly medicine audits did not review all medicines administered to people. This meant concerns were not identified and responsive action was not taken to keep people safe.

Systems and processes were not in place to ensure the proper and safe management and oversight of medicines. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the provider had implemented processes and systems to reduce the likelihood of people's medicines running out. Staff were proactive in their assessment of available medicines, and this included advance reviews, and support prompts for people who ordered their own medicines.
● Focused medication competency assessments had been introduced for staff. Staff told us of their understanding of critical calls, and the importance of administering medicines at the right time where these needs had been identified. Whilst the enhanced competency assessment process was underway, interim assessments continued for staff as part of their supervision process.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the safety and welfare of people. This had put people at risk of harm. This was a breach of regulation 12 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 at risk due to ineffective assessment, monitoring and management of safety. Risks to people had not been thoroughly assessed and reviews did not always take place following an incident or hospital admission. The registered manager did not have oversight, and effective auditing of care plans was not embedded at the service.
● People were at risk of skin damage. At the last inspection we identified risks to people had not always been identified or assessed. This remained the same. Risk assessments had not been completed for those at risk of pressure sores, and care plans were not fully reflective of the support people required to mitigate this risk.
● Risks had not been identified and assessed for all people with dementia, epilepsy and those who may show distress. We found one person was at risk of self-neglect. There was no risk assessment in place, and the care plan did not reflect the person's needs. Furthermore, we found risk assessments relating to nutrition and hydration were not always reflective of people's requirements.
● Risk assessments did not always consider individual needs and were in conflict with other records. For example, one person's care plan stated staff should leave their left-side bedrail down and referred the reader to the risk assessment. However, the risk assessment did not contain this information, was generic, and stated staff should not leave the person with their bedrails down. We found risk assessments were not always personalised, nor did they fully assess the risks to people where mitigation should be explored.
● Since the last inspection, staff training was underway in areas specific to the needs of people such as diabetes and epilepsy, however, not all staff had completed this. The registered manager told us people who had epilepsy were supported only by staff who had completed this training. However, we found this was not the case when reviewing care visits against staff training records.

We found no evidence that people had come to harm, however, people remained at risk. Assessments had not been completed, or were not robust, to mitigate risks to people's health and well-being. Staff had not received training to provide care in a safe manner. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our last inspection, the provider had transferred care documentation from a paper-based system to an electronic system. This system could allow for a more robust approach to risk and safety monitoring; however, further development and management oversight was required.

Preventing and controlling infection

At our last inspection the provider had failed to ensure infection control processes were robust. This had placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made in this area and the provider was still in breach of regulation 12.

● The registered manager had not ensured infection control risks had been assessed and mitigated.
● People considered vulnerable did not have individual COVID-19 risk assessments in place. Guidance was therefore unavailable to staff to mitigate risk. This was identified at the last inspection, and the provider had failed to take responsive action.
● Staff shared an inconsistent approach to COVID-19 testing. The guidance for testing changed during the inspection timeframe, however, no clear procedures were in place at the location to monitor staff adherence

to testing guidelines. The provider told us they relied on the local authority to share guidance with them, and they had not proactively reviewed guidance themselves. The registered manager responded immediately to our feedback and implemented monitoring systems; however, these had not been routinely in place prior to our inspection and were not embedded into practice. People had been placed at risk of infection due to the absence of management direction and oversight.

We found no evidence that people had come to harm, however, infection control processes were not robust. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had undertaken training in infection control, and the safe and appropriate use of personal protective equipment (PPE). People and relatives told us staff wore PPE when visiting.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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 did not operate effective systems to ensure staff were skilled to meet the needs of people. Whilst staff were provided with access to training, there was no evident oversight for the completion of specific courses. For example, we found long standing staff had not consistently completed training which new staff received during their induction. This included key topics such as skin, continence and catheter care training.
- 'Care assessors' were employed to undertake assessments and reviews with people. This role included the development of people's care plans, risk assessments and medicine records. Care assessors had completed 1-day 'care and support planning' training, amongst other courses. However, the findings of this inspection did not evidence training had been sufficient to assess and review the needs of people, and this had not been identified by the provider.

We found no evidence people had come to harm; however, effective training had not taken place. Systems and oversight required review to ensure the training needs of staff were identified. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received an induction programme when beginning their employment. Regular supervision, and appraisals were completed in line with the providers procedures.

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

- The provider had systems and processes in place for people's needs to be assessed, however, these were not always put into practice. Care plans were task focused opposed to providing the needs and preferences of people, and what was normal for them. We found people's care needs were not always formally re-assessed following an incident or change in health.
- People told us they had received initial care assessments, when they began using the service, and routine reviews took place. One person told us, "Yes, I am involved, and I had a review recently." Another person said, "Yes, the manager came out to see me and my [relative] and we went through my package."

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with meal and drink provision where it was part of their care package.
- People and relatives told us staff provided the support required to eat and drink enough. One person said, "[Staff] make me a sandwich and a hot drink. They know I like sandwiches made with brown bread." One relative said, "[Staff] do this, [they are] quite thorough, and they check [person] is coping with certain foods

because of [medical condition]." Staff told us they offered choice to people by visually presenting food options to them, if required.
● Staff took action to make sure people had food available throughout the day, between their care visits. However, it was not clear how risk reducing measures had been discussed with people where sandwiches and cakes were left at room temperature for a period of time.

We recommend the provider considers consulting with people to review how risk reducing measures may be implemented to support food safety.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access health and well-being services where required. Staff reported changes or concerns to their supervisors for reviews and action to be taken.
● People were supported to access medical reviews and receive assessments from services, such as occupational therapists and social workers. People's records did not always evidence the follow-up action taken, however, staff told us action took place and they received updates in most cases.

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 MCA 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

● At the time of inspection, the registered manager told us people either had capacity to make their own decisions or were supported by appointees or family members. The registered manager confirmed there were no best interest decisions in place for people.
● Capacity assessments had been completed as part of the care planning process. People told us staff sought their consent to provide care and support. One person told us, "[Staff] know what I like. They ask me for my agreement."

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 our last inspection we rated this key question good. At this inspection the rating has 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; Supporting people to express their views and be involved in making decisions about their care

- People and relatives said they experienced continuity as the same care staff regularly visited which helped to build trust and familiarity. We received positive feedback regarding the quality of care and support visiting staff provided to people. However, some people said as their care visit times were variable, this had a negative impact on their lives. For example, one person contacted us during the inspection timeframe and said they felt unable to plan their day due to not knowing when carers may arrive.
- People told us they did not feel part of their care visit planning. Some people had become accustomed to not knowing when to expect their care visits, and people told us of their frustrations.
- People said when their visit schedules were requested, they could be changed, and they were not always updated. People shared variable feelings when reflecting on their care experience and sharing them with office staff. One person said, "It would be a waste of time and would cause me more grief, so what is the point." Another person said, "The office doesn't take notice of my concerns, the boss never rings me back." A third person said, "[It's] not worth doing as nothing changes."
- However, people told us the care and support they received from the visiting carers was positive. One person told us, "My regular carer is excellent." Another person said, "They are so lovely, angels." A third person said, "They are tremendous, I am beyond happy."

Respecting and promoting people's privacy, dignity and independence

- People said their privacy and dignity was respected by visiting staff. Staff were aware of the agreed methods of gaining access to people's properties.
- People told us staff entered their homes in their agreed and preferred way. One person said, "[Staff] knock on the door and call out that they're here. They don't come in straight away; they poke their head around the door first." Another person said, "They knock on my door before they come into my room." Relatives told us they found visiting care staff to be discreet, and sensitive to the needs of their family member.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating 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

● Care plans were not personalised and did not evidence how people's preferences were met. Where people required assistance with personal care, for example, care plans did not detail what the person could, or would prefer to, do for themselves. Furthermore, they did not explore what support the person would like to receive from staff. We saw evening care visits did not always consider support with personal care such as a wash, or oral hygiene, when this was identified as a need for the person and was supported in morning visits. There was no evidence of how preferences were reviewed with people as part of the care planning process.

● One person told us, "They won't let me do my wash, and I insist I do this myself as I want to be independent. I had to explain to [staff] to put soap on the flannel for my wash, as they didn't do this. [They] just gave me a wet flannel." This was not all people's experience; however, our review of care plans did not identify how person-centred care was explored with people. Care plans did not promote and detail the desired outcomes and requirements of people or provide guidance for staff.

Care plans were not personalised and did not reflect the required support needs and preferences of people. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns.

● The provider had a complaints procedure and we saw numbers of complaints had decreased over time. The provider had responded to recorded complaints and concerns inline with their policy.

● People and their relatives told us they knew how to raise a complaint or concern. We received mixed feedback relating to how complaints and concerns were handled and whether they reached a satisfactory outcome.

● For example, one person told us, "I know how to complain and did once when the carer didn't turn up. I've had no trouble since." Another person said, "I have complained about [issue] and [staff] being rude to me. This has been resolved to some extent. It's still not perfect." A further person said, "Nothing has changed, that's why I want to change service."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People were given information in an accessible way. The provider told us information could be provided in large font or braille. Additionally, pictorial formats could also be explored.
● People told us they received information in a way which met their communication needs.

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
● Where community activities and support formed part of people's contractual agreements with the service, this took place. People were supported with shopping and attending occasions of importance.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to ensure systems were in place or sufficiently robust to demonstrate the quality and safety of services was effectively managed. This was a breach of regulation 17 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.

- Following the last inspection, the provider was issued with a warning notice. This was to ensure the required improvements were made and to ensure that people received safe care that was well managed. We found that the provider had failed to meet the requirements of the warning notice.
- The provider had failed to ensure systems had been robustly reviewed since our last inspection. The breaches of regulations had not been considered holistically, to develop oversight and continuous learning to improve care. The provider remains in breach of all regulations identified at the last inspection.
- The findings of this inspection did not evidence good outcomes for people. People did not always feel listened to or feel able to approach the provider to openly discuss their experiences. People did not have robust assessments or plans of care in place which promoted person-centred care. The provider's quality assurance and governance systems were not always effective and had not identified the concerns found during this inspection.
- Oversight, analysis and procedures required development in several areas. Systems were not embedded into practice to promote safe care and ensure ongoing monitoring of service provision. We found a variable planned call time process operated at the service. This meant the planned call times for people varied, and call target compliance set by commissioners appeared favourable due to this. This approach did not promote good outcomes for people, nor did it allow the provider to correctly measure and report on their performance against agreed contractual timeframes. The provider told us they were unaware this practice had been taking place. This demonstrated a lack of robust oversight.
- People were at risk due to unsafe medicines management. People's safety was not considered and assessed, to ensure critical care call times were a priority. Risk's to people had not been measured in all instances, and we found audit approaches were ineffective.

● We found the locations CQC rating was not subject to the provider's systems and governance to ensure it was available to the public.
● The registered manager completed a quality assurance survey with people in 2021. Analysis and action had been taken to review the experience of people; however, it was not clear how ongoing satisfaction and monitoring took place outside of this event. The outcome of the survey had not been shared with people for them to have insight of the results and the response compiled by the provider.
● Staff provided variable feedback of their communication experience with the provider, registered manager and office staff. Some staff told us they received positive responses when making contact, and this was supportive. For example, one staff member told us senior staff were available evenings and weekends, and there was always someone to talk to and help them. Others told us their contact was not always responded to, or it took several attempts for their contact to be returned. For example, one staff member said they could not get hold of office staff by telephone, and only received a response on their second or third email.

Systems were not robust to demonstrate the quality and safety of services were effectively managed. Management oversight and processes continued to require development. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our findings throughout the inspection process. For example, we were told action had been taken to ensure the registered manager developed oversight of planned care visit times. Furthermore, we were told risk assessments were being reviewed. The provider told us of their plans to undertake further quality assurance activities with people following our inspection.

● Staff meetings took place, and staff told us they were provided with meeting minutes if they could not attend. Staff told us they faced difficulties with the rise in fuel costs, the provider told us they responded to this with financial uplifts.

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 registered manager and provider were aware of their responsibilities to be open and honest when things went wrong. The provider had shared the previous inspection outcome with staff, people and their relatives. The safeguarding lead told us they had undertaken specific training in the duty of candour, and they had found it beneficial to their role.
● Since the last inspection, where staff had identified concerns, improvements had been made in reporting these to the local authority. And, where required, statutory notifications were submitted to CQC.

Working in partnership with others
● Since the last inspection, the provider had worked with local authorities to review their practice and the service provided to people. Feedback from local authorities included the provider was responsive to change and ongoing improvements.
● The provider told us they participated in local authority meetings. This included participating in safety initiatives for people, such as hospital avoidance delivery groups.

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 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not personalised and did not reflect the required support needs and preferences of people. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not robust to protect people from abuse. Procedures to identify time critical medicines, in line with people's health and well being needs, had not been reviewed in all instances since our last inspection. People did not always receive their medicines at the prescribed optimal time. People were at risk of harm due to neglectful practices. Regulation 13

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk due to variable call times. People's planned care call times were not scheduled for their contracted times. Whilst care visit compliance appeared to meet satisfactory targets, we found this was a changeable approach, which not only had an impact upon people, but did not evidence

robust oversight. People were not always confident when to expect staff to arrive. The provider continued to experience difficulties recruiting staff and had continued to accept new care packages. We found care visits were often shorter than the contracted call duration and no oversight was in place regarding this.

Regulation 18

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk due to ineffective risk and safety management. Risk assessments had either not been completed, or were not robust, for people with health conditions, such as dementia and epilepsy. People at risk of pressure sores did not have risk assessments in place. Medication management was not safe and people were at risk due to ineffective medication administration timescales and the development of medication administration records. People's health needs had not been a priority when considering care visit timings, and this had not been identified as part of the quality monitoring process by the provider. The provider had not completed COVID-19 risk assessments for vulnerable people since our last inspection. There had been no management oversight or effective direction to ensure staff undertook COVID-19 testing inline with government guidance. Regulation 12

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight, analysis and procedures required development in several areas. Systems were not embedded into practice to promote safe care and ongoing monitoring of service provision. We found a variable planned call time process operated at the service. People did not have robust assessments in place which promoted person-centred care and management of medicines was

not safe. The provider had not ensured their legal duty to display their CQC rating at the location. The provider, and registered manager, had not ensured systems had been robustly reviewed since the last inspection. The breaches of regulations had not been considered holistically to develop oversight and continuous learning to improve care. The provider remained in breach of all regulations identified at the last inspection.

Regulation 17

The enforcement action we took:

Warning Notice