Pinnacle Brit Care Ltd

Pinnacle Brit

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pinnacle Brit provides personal care and support to older people and people with disabilities living in their own homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. At the time of our inspection, all 14 people received personal care.

People's experience of using this service and what we found
As in the last 3inspections, risks associated with people's care were not being managed safely. The provider did not have robust systems in place to ensure staff attended the care call and stayed for the full length of the call. Medicines were not being managed in a safe way.

Staff training and supervision were not effective in ensuring good quality of care or identifying and addressing shortfalls. People were not always supported to have maximum choice and control of their lives.

People's independence was impacted as staff were not always advising them when they were going to be late. People and their families did not always have input into their preferred call times which they fed back impacted on their lives.

As from the previous inspection, there was a lack of personalisation and detailed guidance for staff specific to each person's needs. There was a lack of detailed information on people's preferences, their likes and dislikes and life histories and staff confirmed to us they did not know this information. There was a lack of evidence of robust investigation into the complaints or actions taken to make the necessary improvements. People and relatives were not always confident complaints would be addressed.

There remained a lack of robust systems in place to monitor the delivery of care and this impacted on the care people received. The provider had failed to ensure there were robust systems in place where staff either arrived late for a call or did not stay for the full length of the call. Audits taking place were not identifying or preventing issues occurring or continuing at the service. The provider failed to have effective systems in place to gain feedback from people, relatives and staff about the quality of care.

People fed back staff were not always adhering to infection prevention controls. We also found staff were not always recording how much people had eaten and drunk. We have made recommendations around both areas.

There were people and relatives that fed back they had developed good relationships with their regular carers. We saw external professionals were contacted where staff had a concern about a person's health.

Rating at last inspection
The last rating for this service was inadequate (published 29 September 2022) and there were multiple

breaches of regulation. At this inspection, we found the provider remained in breach of regulations. The service remains rated as inadequate overall. This service remains in Special Measures

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 have identified breaches in relation to risks associated with people's care, and the management of medicines. We identified breaches in relation to the deployment of staff and lack of robust training and supervision. We identified breaches in relation to care not being planned and provided around people's needs and wishes and there was a lack of robust oversight of the quality of care and responding and acting on complaints.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service remains '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 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.

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

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 effective. Details are in our effective findings below.	**Inadequate**
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 responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pinnacle Brit

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
Our inspection was completed by 2 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

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.

Inspection activity started on 5 May 2023 and ended on 15 May 2023. We visited the location's office on 5 May 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. 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 gained feedback from the local authority.

During the inspection
We called and spoke with 3 people and 5 relatives of people who used the service about their experience of the care provided. At the office we spoke with the provider who is also the registered manager and 2 members of staff. We called and spoke with 3 members of staff.

We reviewed a range of records including 8 people's care plans, daily care notes, staff rotas, multiple medication records, safeguarding records and complaints. We reviewed a variety of records relating to the management of the service including 3 staff recruitment files and spot checks.

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.

Staffing and recruitment

At our last inspection we found there was lack of organisation by the provider to ensure staff stayed for the full length of the care call which we found impacted on people's lives. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst there had been some improvements the provider remained in breach of regulation 18.

● Despite the provider telling us there were systems in place to ensure staff remained at the service for the full length of the call, people and relatives continued to feed back this remained a concern. Comments included, "I wouldn't say they stay for full call but stay long enough to make sure I am ok", "I have them booked for an hour which I pay for but usually here for 30 mins" and "We say cheerio after about 10-15 mins (for a 30-minute call)."
● Staff were required to log into the services online system using a handheld device when they arrived at a call and when they left. We reviewed the records of this and found there were multiple occasions where staff had failed to log onto the call. For example, according to the staff communication record for April 2023 there were 62 occasions of staff not logging into the care calls for 9 people. This meant the provider could not be assured staff were present for the full length of the call.
● The provider was also not assured that 2 staff were attending the full length of the call where this was required. There were occasions the second member of staff had not logged on to the care system. One person told us they required two staff to attend the call but told us there were times only 1 member of staff turned up. They said, "I don't know why I get one carer when it should be two."
● As identified on previous inspections, staff were not always arriving at calls at the agreed time which was impacting on people's care. Comments from people and relatives included, "We never really know what time (member of staff) will appear. It can be frustrating" and another said about carers being late, "The problem is (family member) gets put to bed at 19:00 the night before so is in bed this whole time."

As staff were not deployed in a way to ensure that all calls were attended, this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not operate safe recruitment practices when employing new staff. Since the last inspection the provider had recruited additional staff. One member of staff's references were typed up and not dated. There was no evidence in the recruitment file of how either referee was contacted to provide these, despite both written letters being addressed to Pinnacle Brit. The provider told us they had called both referees to verify they were legitimate but there was no evidence of this. The details of their employment also did not match the names of either company on the references.

● Another member of staff's application form was signed as completed after the date the member of staff signed their contract to start work. This meant they were offered the position before the provider had full information on the member of staff's employment history. We saw from their application form there was a gap between February 2023 and April 2023 with no evidence of the provider asking for an explanation. One of the references for the member of staff was typed up and not dated. There was no evidence in the recruitment file of how the referee was contacted to provide this. The provider told us they had called the referee to verify they were legitimate but again there was no evidence of this.
● A third member of staff's two references were taken over the phone by a representative of the provider. However, there was no detail on who the referees were in relation to the organisations the member of staff stated they worked for.
● The provider told us a representative of a consultant they had been using to assist with audits was also attending people's homes to undertake staff's observed practice. However, they had not undertaken any background checks to determine this representative was suitable to be visiting people in their own homes. The provider told us they had undertaken a Disclosure and Barring Service (DBS) check however they were unable to provide us with evidence of this.

The provider failed to undertake robust recruitment practices which is a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) for all other staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last three inspections of the service, we found the provider had not ensured the risks associated with people's care were being managed in a safe way. 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 remained in breach of regulation 12.

● Whilst there had been some improvements in care plans around the assessment of risk at the previous inspection, this had not been sustained. We identified multiple instances where risks had not been assessed or actions taken to mitigate these risks.
● One person had diabetes yet their eating and drinking risk assessment had no guidance for staff on signs to look out for should the person become unwell including ensuring they were drinking and eating well. This was despite their relative and staff telling us there had been occasions where they had found the person had become unwell due to not eating and drinking enough.
● Another person was epileptic however there was no risk assessment in place in relation to this and no guidance for staff in the event the person had a seizure. This meant staff may not provide the most appropriate support.
● According to the provider 1 person recently returned to their home from a short stay in hospital. It was identified by staff the person had developed pressure sores on their back which was reported to the district nurse. However, the person's skin integrity risk assessment had not been updated in relation to this and stated the person's difficulty with skin was 'measured' as 'minor'. There was no additional guidance for staff on measures to reduce the risk of pressure sores other than to contact the office.
● We saw from an incident form staff reported a person sustained an injury to their eye. A photograph was taken, and a body map was completed. Other than reporting this to the district nurse, there was no other information on any investigation to determine the cause of the injury.

● Although staff were now recording some incidents, there was little evidence of learning from these incidents. For example, the provider sent us an analysis of incidents. It stated there had been 11 incidents relating to pressure sores. However, there was no information on what preventative measures had been taken other than to state the people were prone to developing pressure sores. It stated care plans were in place to help guide staff, however as stated above the care plans lacked guidance.

As risks and incidents were not being managed in a safe way, this is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were not always being managed in a safe way. One person required support with their time critical medicine. It was important for the person to have this medicine at the same time each day. However, there was no reference to the importance of this on the person's medicine administration record (MAR). We saw from the record of when the medicine was given there was a difference of up to 2 hours before the medicine was given in the evening each day. This put the person at risk of becoming unwell. A member of staff said, "I haven't been told about (giving) medication at the same time."

● We saw from 1 person's care notes staff recorded they regularly applied cream to a person's legs. This was also referenced in the person's care plan. However, there was no MAR for this cream detailing what the cream was, how it should be applied and the frequency. In the summary 'daily routine' record it stated staff were to administer the person's medicine however in another section it stated the person self-medicates. This meant there was a risk either staff would not apply the cream as required or attempt to administer other medicines to the person when it was not required.

● People's MARs did not contain a photo of the person, information on any known allergies or how the person preferred to take their medicines. At the end of each MAR, there was details of all missed medicines for that month. It was not clear from the MARs or the care records whether this was a records issue where staff had been unable to log on the electronic care plan or whether the person had actually missed their medicine that day.

As medicines were not managed in a safe way, this is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● There were mixed responses from people and relatives about whether staff wore personal protective equipment (PPE). Comments included, "If I am honest, (member of staff) already has their apron on and mask and then put their gloves on. They always do that. (Another member of staff) rarely puts anything on" and, "They just wear gloves and throw them into our bin."

● Staff we spoke with had a good understanding of how to prevent infections. One member of staff told us, "People we support don't have strong immune systems. It's making use of your PPE gloves, aprons and face mask. Disposing properly is just as important."

● The provider told us staff were able to access PPE in the office or in people's homes. The provider said, "We have different destination points. The carers come to the office to get PPE when they come for supervision."

We recommend the provider ensures staff are adhering to the polices around infection, protection and control.

Systems and processes to safeguard people from the risk of abuse.

At our last inspection of the service, we found the provider had not ensured people were protected from the risk of abuse and neglect. 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. There had been improvements at this inspection and the provider was no longer in breach of regulation 13.

● People told us they were not concerned how staff would treat them. One told us, "I feel safe with them." One relative told us, "(Family member) seems to get on alright with staff, he doesn't feel unsafe."
● Staff received safeguarding training and there was a whistleblowing policy that staff could access. Staff were aware of the signs to look out for with 1 telling us, "It could be a drastic change in character. If they (people) are quieter. There could be sores on their body, scratches and bruises." Staff told us they would not hold back on whistleblowing if they had a concern.
● We saw that where there were any concerns raised, the provider would raise this with the Local Authority.

Inadequate

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 inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our 2 last inspections of the service, we found the provider was not ensuring staff were adequately trained and supervised in relation to their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 18.

- People and relatives did not always feel staff were appropriately trained. One relative said, "I don't think they (staff) really understand what (health condition) is."
- People were not always supported by staff that had undergone a thorough induction programme to give them the skills to care for people effectively. The provider told us all staff before they started working independently would undertake shadow shifts with a more experienced member of staff. Work shadowing involves observing a professional to gain a better understanding of the role. However, we noted from the shadow shift records this consisted of the member of staff delivering the care. This meant the member of staff did not have an opportunity to observe practices.
- Although we saw from records staff received training, this was not effective in ensuring they understood this in practice. When we spoke to staff, they lacked an understanding of the health conditions of people they were supporting. In reference to Parkinson's 1 member of staff told us, "I have heard Parkinson's being discussed. I don't know exactly what this is. It would be good to know so we know the level of capability." Another member of staff told us they were aware the person shakes but said, "I don't know too much about that." This meant there was a risk they would not provide the most appropriate support.
- Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. We saw from a safeguarding report completed by the provider in October 2022 that all staff were to receive reflective supervisions around ensuring they always stayed for the full length of the call. However, these were not effective as we continued to identify incidents of this still happening.
- People and relatives told us spot checks were not taking place in the person's home. One relative said, "I don't remember anybody ever coming to do a spot check. I think that would be important." The spot checks we did see evidence of were a check list of work observed. However, these forms completed did not correspond with person's needs. One check list stated the person was shaved and the person was hoisted safely. However, neither of these tasks were required for this person.

As there is lack of staff training, knowledge and competency this is a continued breach of regulation 18 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our 2 last inspections of the service, we found the provider was not adhering to the principles of MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 11.

● As at the previous inspection, we found the provider was not aware of the principals of MCA which meant there was a risk consent was not gained from people appropriately.
● The provider told us there were no people at the service that lacked capacity to make decisions. However according to 2 care plans we looked at it stated the person's capacity was in doubt due to their cognitive impairment.
● Where people's capacity was in doubt, it was recorded on their consent form. One person had signed to consent to care and another person had verbally agreed to care. No assessments had been undertaken in relation to either person to determine whether they had the capacity to consent to their care.
● One person who had full capacity to consent to care had a note in their care plan that stated, "Ensure my tasks should be completed in my best of interest." This meant there was a risk staff would provide elements of care without ensuring the person had given their full consent.

As the requirement of MCA and consent to care and treatment was not followed, this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People told us where needed they were supported with their meals. However, where staff were running late this meant there was a risk people would not receive appropriate nutrition and hydration in a timely way.
● Staff were not always recording whether people had been eating and drinking well. This was particularly important if people needed additional support and reminders to eat and drink. One relative told us, "Sometimes (family member) gets dehydrated, they give her a drink and don't ever make sure she drinks it."

We recommend the provider ensures staff record information on how people have been supported with

their nutrition and hydration.

● There were records in people's care plans on their preferred food and drinks and information around foods that needed to be avoided.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection of the service, we found the provider was not ensuring care professionals were consulted when they had concerns with people's health. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9 in relation to this.

● Aside from the nutrition and hydration concerns, the provider and staff monitored people's health and liaised with relevant health care professionals to ensure people received the care and treatment they required.
● We saw the provider had contacted a district nurse in relation to concerns about a person's pressure sore and in relation to an injury another person had sustained.
● Staff told us they would ensure they raise concerns about a person's health with the office or health care professionals. One member of staff said, "If there are changes, we put a call through to the office and let them know. The office will tell the other carers about it."

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 inadequate. 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; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At our inspections of the service, we found the provider was not ensuring staff treated people with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10

● At the last 2 inspections, we found people did not benefit from full support from staff as they were not staying for the full length of the call. We continued to find the same concerns on this inspection. People and relatives said as a result the person was at times rushed. Comments included, "They are busy and no time to chat", "They can be rushed when providing care. They have never hurt (family member) but can be a bit brisk" and "They give the impression of being very rushed. They are quire business like with her. Very transactional."
● People and their families independence was impacted as staff were not always advising them when they were going to be late. One relative said, "They can sometimes get there late in the morning. We don't really get told if it's an hour late." Another relative told us they would end up providing the morning personal care when the carer is late.
● People and relatives told us they were not given choices around when they wanted care to be delivered. A relative told us, "We wanted them earlier, but they get there late in the morning. It's something my (family member) would have liked if they could come earlier."
● People and relatives were not asked if they would prefer a male or female carer. One relative told us, "Not asked preference over females but it's a case of he has to have what's available."

As people were not always involved in decisions around their care, this a repeated breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some relatives that told us they were contacted when staff were running late. One relative said, "If they are going to be late the (provider) will telephone to say they are going to be late."
● People told us there were staff that treated them with respect and dignity. One person said, "She (member of staff) respects my dignity. She is a pleasant person." A relative said, "Regular carer is respectful."
● People and relatives told us they had developed good relationships with their regular carers. Comments

included, "They are caring, very much. She (staff member) always asks how I am. She seems to be very caring", "They are very careful with him, they are gentle", "She (member of staff) is a great person to have around. Being regular you get to know her" and "I think staff are caring."

● Staff gave us examples of how they would respect people. One told us, "When you are providing personal care, make sure curtains are closed and then cover the area you are not cleaning. You need to inform them and ask them questions. A lot of people can wash their face so you can encourage them to do this."

Inadequate

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 inadequate. At this inspection the rating has remained inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; 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.

At our last two inspections of the service, we found the provider had failed to ensure care was provided in a way that met people's individual and most current needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

● People's life histories, likes, dislikes and interests remained lacking in their care plans. Whilst there was some information that people had family, there was no further detail including names of family members and important people in their lives. Staff we spoke with were not familiar with people's life histories. One member of staff said, "I don't know about (person's) life history, it would be good to have that information. We need to know more about them for a better connection." Another told us, "Would be good to have the history of people as most of the clients talk about memories, it keeps them going."
● One person's care plan stated they had a mental health diagnosis. There was no information for staff on what this meant to the person and how best to support them. Staff were also not always aware of the health needs of people with 1 member of staff telling us of the people they support, "I don't know their medical backgrounds."
● People and relatives told us they could not recall when the care was last reviewed. Comments included, "There hasn't been a care review for some time", "Quite a while since the care was reviewed" and "Can't recall the last time the care was reviewed here." The provider told us all care reviews were being undertaken remotely however there was no record of this taking place.
● People were not always supported with their end-of-life care planning. There was no information in their care plans on discussions with them and their relatives on their wants and wishes. Although 1 relative fed back positively about the care their family member was receiving; there had been no update in the person's care plan to reflect they were now receiving end of life care. This was despite the provider telling us care was reviewed at this stage.
● There was a lack of information in people's care plans on how they communicate or guidance for staff. One person's first language was not English, and they had reverted to speaking in their native tongue. There

was no information in the care plan they had been offered information in the person's native language.
● We saw from another care plan the person's speech was impaired due to their health condition. The care plan lacked information on how best to the support the person with this other than to stand in front of the person and speak clearly. This was not reflective of how staff should best assist the person to communicate their needs.

Care and treatment was not provided in a way that met people's individual and most current needs. This is a repeated 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

At our last two inspections of the service, we found the provider had failed to investigate and take action when complaints were made. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 16.

● People and relatives did all not always feel confident their complaints would be responded to. Comments included, "I ring them from time to time to say they are arriving late. To be honest there isn't an awful lot of point, it's not an effective process" and "I think I would feel listened to, but I don't complain, I sort of accept what they do."
● There remained a lack of robust investigation into the complaints or actions taken to make the necessary improvements. We saw from a staff meeting in January 2023 staff were being reminded to ensure they were not charging their phones at people's houses as complaints had been received. This was not recorded in the complaints folder and there was no evidence of an investigation into this.
● A relative told us they had made a complaint to the provider about staff not ensuring their family member had been eating and drinking. The provider also told us they were aware of this concern. However, this was not recorded in the complaints folder and there was no evidence of an investigation into this other than the provider telling us they spoke with staff about this.
● Another relative told us they had made a complaint in relation to the conduct of a member of staff who was observed to have been laying on their family member's bed. Although they stated the provider addressed this, there was no record of this in the complaints folder.

As complaints and concerns were not always investigated and appropriate action taken this is a repeated breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. At this inspection the rating 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

At our last 3 inspections of the service, we found the provider had not ensured there was ongoing and robust management oversight to ensure changes and standards were maintained. 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 not been made at this inspection and the provider remained in breach of regulation 17

● The provider failed to ensure there were effective systems in place to monitor the delivery of care. This impacted on the care people received. Since the last inspection, the provider had been required to send us monthly reports of the oversight of care. We found evidence on this inspection that did not accurately reflect what we were being told on the reports and the provider had failed to send in a report since March 2023.
● The last required audit report in March 2023 from the provider stated, 'We are updating existing care plans to ensure that they have been written to reflect a person-centred account of the support that we are providing including the likes and dislikes; strengths; abilities; what the service user can and can't do and their interests' and 'We will use the risk assessments about the health, safety, and welfare of people using our service to make the required adjustments. These adjustments may be to premises, equipment, staff training, processes, and practices.' We found this was not in place and continued to identify concerns in care plans and risk assessments.
● At the last inspection, we identified staff were not staying for the full length of the calls. We continued to find this despite the provider telling us on this inspection this was no longer a concern and that they had better oversight of this. The system the provider had in place for monitoring this was not robust as frequently staff were not logging on to the care call.
● The lack of openness and transparency from the provider remained a concern at this inspection. At the start of the inspection the provider told us there were office staff in place to assist with monitoring the oversight of care calls. They told us one of these staff members worked Monday to Friday in the office and picked up the occasional care call. However, staff rotas showed the member of staff was regularly rostered to provide care through the week. The member of staff told us they were recruited as a carer but would help out in the office when there were not enough care calls for them.

The failure to ensure quality assurance and governance systems were effective and records related to the provision of support for people were adequately maintained is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was a mixed response from people and their relatives on the communication from the office. Comments included, "We don't hear from them all that often", "Its ok, they do ring us occasionally. Mainly if they are going to be really late" and "Very rarely get a call. On some occasions it would be good and knowing generally the time span if they are going to be late."

● Most people and relatives we spoke with could not recall being asked to complete a survey. One relative said, "I don't think that's ever occurred." Another told us, "I don't think we have filled in a survey" and a third said, "I think we had a tick box survey."

● The provider was not always using formal feedback to make improvements. We saw of the 4 surveys completed in December 2022; 3 forms were ticked that the person was not contacted by the office when staff were running late. There was also feedback staff were at times running late. There was no action plan to state what actions were being taken as a result and we continued to find these concerns.

● Whilst staff meetings were taking place, this was not used as an opportunity to gain feedback on the continuous issues around staff not being able to log on to calls or ask staff for areas that could be improved upon.

● The provider lacked robust systems to continuously learn from shortfalls in care and make improvements. We noted from the staff communication log there were multiple occasions in January, February, March and April 2023 where staff were not logging into the care calls. There was no action taken on what the issues were for learning and improvements.

● Although the provider had an of understanding of duty of candour in practice, they were not acting on this. The provider told us, "Ensuring we are transparent. Making sure if concerns are raised with us, we need to put our hands up and feed back to service users on the outcome of our findings. Share the lessons learned." However, where concerns had been identified from complaints made by people and relatives there was a lack of evidence they had been written to with the outcome of any investigation. This meant there was a risk when something went wrong at the service, the provider may not follow the current procedures of informing people about the incident, providing truthful information and an apology when things go wrong.

The failure to ensure the service performance was evaluated and improved is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There was positive feedback from staff about the management team. Comments included, "I do feel supported, I was given proper training. Where there is an issue, I can contact the office and get an immediate response" and "I am happy with the job."

Working in partnership with others

● The provider worked with external organisations in relation to people's care, including health care professionals and Local Authorities. The provider told us, "We work quite well with professionals. We are very proactive. We follow up with an email where required. Just to put them in the loop of what's happening (with the person)."

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of events including significant incidents and safeguarding concerns.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was not provided in a way that met people's individual and most current needs.

The enforcement action we took:

We have cancelled the providers registration

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always involved in decisions around their care.

The enforcement action we took:

We have cancelled the provider registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure the provider the requirement of MCA and consent to care and treatment was followed.

The enforcement action we took:

We have cancelled the provider registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's care, medicines and incidents were being managed in a safe way.

The enforcement action we took:

We have cancelled the providers registration.

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints and concerns were always investigated and appropriate action taken.

The enforcement action we took:

We have cancelled the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance and governance systems were effective and records related to the provision of support for people were adequately maintained. They failed to ensure the service performance was evaluated and improved.

The enforcement action we took:

We have cancelled the providers registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to undertake robust recruitment practices.

The enforcement action we took:

We have cancelled the providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were deployed in a way to ensure that all calls were attended and failed to ensure staff were appropriately trained and supervised.

The enforcement action we took:

We have cancelled the providers registration.