Professional Care Services Bucks Limited

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Inspection report

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16 February 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Professional Care Services Bucks Ltd is registered to provide personal care and support to people in their own homes. 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. At the time of the inspection the service supported 93 people.

People's experience of using this service and what we found
People were not routinely provided with person-centred care. People told us care was regularly unplanned and they were left uncertain as to who was going to attend. A person commented, "We were supposed to have one girl for most of the mornings, but we are getting loads of different people, never know who is coming and then you have to explain it all over again."

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; as the policies and systems in the service did not support this practice. We found the service failed to act in accordance with the Mental Capacity Act 2005.

The provider did not enable people to be involved in making decisions about care and people were not routinely supported as they wished. The general feedback received from people and those who represented them about the lack of timely calls, continuity of care, and negative impact of the registered manager's behaviour towards them meant people were not treated with dignity and respect all times.

People were not routinely and effectively protected from potential avoidable harm. The provider had not ensured they had done all that was reasonably practicable to mitigate risks. The registered manager and nominated individual were unable to demonstrate a good understanding of risk management. We found people were placed at potential risk of harm due to the poor management of risks.

Systems were either not in place or robust enough to ensure the proper and safe management of medicines and the provider failed to follow government guidance in relation to wearing personal protective equipment (PPE) in the office to prevent and control the spread of infection in relation to COVID-19.

People were not always adequately protected from abuse or the risk of improper treatment as systems and processes were not operated effectively at the service. The registered manager did not ensure staff took appropriate action when an accident or incident happened.

The provider failed to protect people from risks posed by staff. Recruitment systems and processes in place were unsafe. Pre-employment checks were not robust and did not fully assess the candidate's suitability for the role. Disciplinary records showed two staff had committed acts of gross misconduct following their appointment and were dismissed. The recruitment records for both members of staff showed that issues of

concern were not followed up during the recruitment process which could have prevented this.

The provider did not make sure there were sufficient suitably qualified, competent, skilled and experienced staff and staff were not appropriately supported to ensure peoples' care needs could be met. Assessments of people's needs were ineffective as they failed to include all of peoples' needs and expected outcomes for supporting people with meals, were not always met.

People's preferences for care and support were not fully reflected in care plans, this included wishes and preferences for end of life care. Reviews of care did not ensure the care and support delivered still met people's needs. This meant people could not always be confident the service would be responsive to all their care and support needs.

The registered manager demonstrated a lack of understanding about how to manage concerns raised. We found the provider did not operate an accessible system for identifying, receiving, handling, and responding to complaints.

People and staff told us about their concerns about the culture of the organisation but felt unable to share these with the provider for fear of repercussions. There was a lack of confidence in the registered manager's ability to run the service. Comments included, "Quite frankly the owner of the company is not fit to be a business owner. She takes it all personally and does not take the patients' perspective" and [name of registered manager] is really intimidating."

The service did not actively encourage feedback about the quality of care and support delivered. Quality assurance systems were ineffective and had not identified the concerns we had found during our visits. Where information was gathered, they failed to analyse the data to establish if there were any patterns or trends and, use any findings to drive improvements.

We found multiple breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Rating at last inspection
This service was registered with us on 2 May 2019 and this is the first inspection.

Why we inspected
This was a planned comprehensive inspection to assess compliance with the regulations since the service was registered. The inspection was prompted in part due to concerns received about the management of the service. Several concerns had been raised with us about the conduct of the registered manager, staff training, lack of support and supervision for staff and poor planning of care visits.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified multiple breaches of regulation. These were in relation to the management of the service,

the management of risk, safeguarding people from abuse, record keeping related to care provided, complaints, medicines, staff recruitment and ongoing support and monitoring of staff performance and training. The provider had failed to notify CQC of certain events, to comply with the Mental Capacity Act 2005 and to monitor and improve the quality of the service to people.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Professional Care Services Bucks Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and three Experts by Experience. The Experts by Experience made telephone calls to people and their relatives. 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the registered manager is often out providing care and we needed to ensure they were available to support the inspection.

Inspection activity started on 9 February 2021 and ended on 23 February 2021. We visited the office location on 9, 11 and 16 February 2021.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. Throughout the inspection we provided the registered manager with opportunities to share what they did well with us.

We reviewed information we had received about the service since they were registered. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection-
We spoke with 13 people who used the service and 30 relatives about their experience of the care provided. We spoke with three office staff, seven care workers and received completed feedback questionnaires from eight care workers. We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at 17 care records, safeguarding records, training records, complaints records, six recruitment files, policies and procedures and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who had knowledge of the service and spoke with local authority commissioners.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not routinely and effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required.
- The registered manager and nominated individual were unable to demonstrate a good understanding of risk management. When asked about risk management the registered manager told us "We do things that make it safe." The registered manager was unable to articulate what considerations were required to carry out a risk assessment and how they supported people and staff to maintain their safety.
- The registered manager and nominated individual told us the care plans they had provided to us contained all the risks assessment the service carried out. The care plans we looked at contained as standard an environmental risk assessment, a moving and handling risk assessment and a medication assessment. We found these were not routinely completed in full and did not identify any control measures to reduce potential harm to people.
- We found even when risk assessments had been completed these failed to be effective in managing potential harm to people. One person's moving, and handling risk assessment stated their bed was not at the right height. No additional guidance was available for staff on how to reduce risk of harm. Another person's moving and handling risk assessment stated the room was restricted, however, no additional guidance was available. The same person's environmental risk assessment failed to identify potential hazards associated with family pets.
- We found risks associated with the condition of people's skin were not always responded to in a timely manner. One person's daily notes referred to an "open wound that is weeping and bleeding." This was recorded on 1 August 2020; we checked the daily notes and saw care workers had continued to refer to the "sore" or "wound" throughout August 2020 and into September 2020. The first record of a district nurse being contacted was 6 October 2020. Another person had waited a week prior to receiving support from the district nurses. Care workers had recorded on 25 January 2021, "Bottom bleeding and sore", on 28 January 2021 "Bottom extremely sore, please get DN to come and see it as it has really broken down". On the 31 January 2021 care workers recorded "Bottom extremely sore please get DN to come see it." Records showed the district nurse was contacted on 1 February 2021. This was an unacceptable delay in obtaining support for the person and had the potential to cause harm to their health and well-being.
- People who had a history of falls identified in their care plans had no risk assessments in place to mitigate or prevent future falls. People who required a hospital bed and had bed rails fitted had not had the risk of their use assessed. There is a known risk of entrapment with the use of bed rails, therefore the lack of risk management plans had the potential to put people at risk of harm.
- Risks associated with people's medical conditions were not assessed. We discussed the lack of risk assessment processes with the registered manager and nominated individual who confirmed they did not

carry out risk assessments relating to people's health. One person was diagnosed with diabetes and was an amputee. No risk assessment was in place on how staff should support them to maintain their health and well-being. People who had medical conditions and were prescribed medicines which had the potential to cause harm were not protected. No risk assessments were in place for people who were administered anticoagulant medicines. These medicines had the potential to cause internal and external bleeding. We found people who were prescribed anticoagulant medicines had experienced falls. No additional guidance was available for staff on how to monitor people who were prescribed these medicines and what they needed to look for as potential signs of excessive bleeding.

● Risks associated with people's mental health conditions had not been assessed. Staff did not have access to any additional guidance on warning indicators to help them identify any deterioration in people's mental health. After our visit, the provider sent documentary evidence to show they had developed risk assessments for various health conditions.

● Systems were either not in place or effective to ensure learning after incidents or accidents. The registered manager did not ensure effective systems were followed to make sure staff took appropriate action when an accident or incident occurred. This placed people at risk of harm.

People were placed at potential risk of harm due to the poor management of risks. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People did not receive continuity of care as the deployment of staff did not consider their needs effectively. People gave their views on staffing levels. Comments included, "The carers are good, I think one of the problems is that [name of registered manager] has taken on more and more over a wider area and struggles with staff" and "They (the service) have a high turnover of staff."

● The registered manager informed us they had challenges with staffing, first they told us they had two staff who had left the service but after further exploration of this, they eventually told us seven staff had left. The registered manager told us they had put in measures to ensure care would be delivered safely but they were not able to provide further documentary evidence to support this.

● People, relatives and staff spoke about the negative impact this had. For instance, a staff member commented, "The major problem with any company is there is no travel time allowed (we don't get paid for that) and sometimes we make mistakes because we need to rush. I won't be able to do this job for a long time and not full time. We need to manage our time so careful." This was supported by a person who told us, "Time keeping is chaotic, breakfast call can be half ten in the morning and then lunch at half eleven. The staff tell us that they have no travelling time, the evening call could be 4.30pm, 6pm or 7pm."

Staff were not effectively deployed to ensure they could safely meet people's care and support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems and processes were unsafe. The provider did not carry out robust pre-employment checks. We viewed six staff files and found instances where information on job applications was not always followed up to assess a candidate's suitability. For example, gaps in employment and reasons why staff had left their previous employer.

● Providers are required to seek references from previous employers before new staff could start working for them. The service's recruitment and selection policy and procedure stated potential new recruits would have to provide "a minimum of two written references, one of which will be from the applicant's most recent employer, and the other either a second employment reference or a character reference." We noted on

some occasions the service obtained references by telephone. There was no evidence that references were verified to ensure that they were authentic and therefore the provider could not be assured that all staff recruited were suitable to work with people using the service.

The provider's recruitment services were not robust and therefore did not protect people using the service from unsuitable staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not routinely protected from potential abuse. Where concerns had been raised by people to the service about the level of care provided, the service failed to report this to the local authority's safeguarding team.

● Incidents and events that happened in the service were not always reported as safeguarding concerns. For instance, one person had complained to the service their care worker had been "Very rough and shouts at her." No safeguarding referral had been made to the local authority. We discussed this with the registered manager who demonstrated a lack of understanding on how to respond to similar concerns.

● We received feedback from people and their relatives and found evidence in records of potential safeguarding concerns. Following the first day of the inspection we made eight safeguarding referrals to two local authorities. We found, people did not have their medicines administered as prescribed, people were left vulnerable due to their front doors being left unlocked, as examples.

● The service failed to protect people from the potential risks posed by staff. For instance, the registered manager recruited two staff despite being made aware one had left their previous employer before a disciplinary hearing could take place and another disclosing they had a criminal offence. The provider's recruitment and selection policy and procedure stated, "A decision to appoint or not will take into account the details of their convictions and the outcomes of a risk assessment, which will ensure that no-one is put at risk from their appointment." Although the registered manager had decided to recruit these two staff, they had failed to adequately risk assess these issues to ensure people's safety. Disciplinary records showed the two staff had committed acts of gross misconduct following their appointment and been dismissed.

The provider had failed to implement effective systems to safeguard people from the risk of abuse. 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.

●Staff told us they had received safeguarding training. Staff told us they understood how to safeguard people. Comments from staff included "To protect the well-being and health of any adult especially those at risk. So that they can live safely free from abuse and neglect", "The online training I have done covered safeguarding. I learnt that in the event I suspect abuse I need to report it to the office. The training is repeated every year" and "Just e-learning courses only. Safeguarding the protection of vulnerable adults' right to live safely, free from abuse or neglect."

Using medicines safely

● People's medicines were not managed safely. Medicines were not always administered accurately, in accordance with prescribers' instructions and at suitable times to make sure people who used the service were not placed at risk. We found records relating to medicines did not always reflect medicines were administered as prescribed. A person's medicines record (MAR) indicated their medicine had to be administered once a week on the same day of the week, first thing in the morning on an empty stomach. The person had to be seated upright for 30 minutes and they should not consume any food (including other medicines) after taking the medicine. The provider's 'active medication list' showed the medicine was

started on 18 January 2021 and was to be administered every lunch time which was not in line with prescriber's instructions. We noted the medicine was administered during the lunch time calls on 25 January, 1 and 8 February 2021. We raised our concerns with the local authority's safeguarding team.
● We found the provider failed to plan care visits to facilitate safe administration of medicine. One person relied upon care staff to administer pain relief. The medicines were locked away for their own protection. We noted care workers had been unable to administer medicines on two occasions in one month as the care visits were not spaced out enough. We saw records stated, "Too early to give him the next lot of medication" and "Refused meds due to lunch call only being there hour before." Another person was prescribed Paracetamol. On 6 February 2021 the care staff administered this at 4.42pm and 7.40pm. This had the potential to harm the person as the two doses were not administered in line with instructions which state there should be at least four hours between each dose.

Systems were either not in place or robust enough to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave us mixed feedback about how they were supported with their prescribed medicines. One relative told us "I've not had any issues with the pills, the carers know us really well and they phone me if anything is running low". Whilst another relative commented, "I come into the house and sometimes find tablets on the floor."
● Where people were prescribed 'as required' medicines staff had no additional guidance as to why, when and how this should be provided. We noted some people's care records showed they had memory issues which may have impacted on their ability to request this medicine. We found care records routinely advised care workers to 'administer dosset box'. Care workers told us they did not routinely know what was contained in the dosset box. For instance, a carer commented, "The dosset box will sometimes state what types of medicines people are taking but sometimes it does not. Where there are medicines which are not in the dosset box it's for staff to take pictures and send to office who will put this on the system. No one visits homes to check we have the right information."
● The provider's medicines policy dated January 2019 stated, the registered manager was responsible for ensuring, 'all staff involved in medication management are trained, assessed and competent to perform the activities required of them within their role.' A staff member commented, "I am up to date with medicine training but my competency to administer medicine has not been assessed." Most of the staff we spoke with confirmed this. Training records confirmed staff had completed on-line medicines training. The registered manager told us they had assessed staff's competency to administer medicines but was unable to provide documentary evidence to support this during or after our visit.
● The service had a policy dated March 2020 for medicines that were bought over the counter and administered as and when required, referred to as PRN medicines. The policy stated, 'Staff should be aware of the possible side-effects of domestic medicines and their possible incompatibility with any other medication the service user might be taking and watch out for such side-effects, whereupon they should seek medical advice immediately.' However, staff told us there were no specific protocols in place when administering PRN medicines. When referring to PRN a staff member commented, "This is hit and miss, [name of person] had medicines which are not part of their dosset boxes, and this is sometimes just left by staff on the couch." The policy also stated, 'All checks, observations and concerns about the safe use of over-the-counter medicines are recorded on the person's care plan and regularly monitored and reviewed. This was not seen in any of the care plans viewed.

Preventing and controlling infection
● The service was not routinely and robustly following government guidance in relation to the spread of

coronavirus. On day one of the inspection we were greeted by the registered manager and office staff who were not wearing any personal protective equipment (PPE). We expressed our surprise about the lack of PPE. The registered manager told us staff were in their "Bubble", however, two staff members had elderly relatives who they visited on a regular basis. The registered manager and one member of staff visited people in their own homes to carry out personal care. This placed people at risk and demonstrated a lack of understanding by the registered manager. We asked the registered manager if they required the current guidance on safe working practices. They told us they did not need this and had knowledge of the guidance. On day two of the inspection we were greeted by the registered manager and office staff who were wearing, gloves, aprons and face masks and had covered their work chairs in protective coverings. This again demonstrated a lack of understanding of the guidance on safe working practices.

● People and their relatives told us staff did not routinely wear PPE. Comments included "I have witnessed a carer giving the medication and dropping it in the bed in front of me, they were not wearing PPE, I did complain, and the person is no longer working for the agency" and "The carers often didn't wear masks properly, they often had them hanging off their faces and I phoned and reported to the manager but she said they were tested every two weeks and she wasn't bothered or interested about the masks." We received feedback from relatives who stated care workers had refused to visit their family member if they themselves were visiting them. One relative told us when they did visit their family member again, they found the fridge full of food that was weeks out of date.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● People were not supported by a service that responded to accidents and incidents in a way that learnt lessons when things went wrong.

● The provider's policies and procedures were not robust enough to ensure all accidents and near misses were recorded and or investigated. People who had fallen or had suffered injuries were not protected from future re-occurrences as steps were not taken to mitigate any identified risks.

● We looked at the provider's policy for the management of incidents dated January 2019. It stated, 'In the event of an accident/incident, staff will ensure that a detailed entry of the event is recorded on an accident form and will notify the registered manager." We looked for completed accident forms, none were present. We discussed this with the registered manager who told us, "We don't record accidents as you would record them." The registered manager informed us they recorded actions following an incident on the electronic recording system and on their tracking spreadsheet. However, we found the registered manager did not complete any analysis or identify trends in accidents and incidents to help prevent their reoccurrence.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

● People received care and support from staff who were not appropriately inducted, trained and supervised.

● The provider's induction and training policy reviewed in January 2020, stated all new staff are expected to attend a comprehension and in-depth induction. This would be aligned with the Care Certificate. The Care Certificate is a set of 15 national standards that new health and social care workers should meet to show they were able to carry out their roles.

● Training records showed staff had completed the e-learning part of the Care Certificate however, the registered manager had not taken action to assess staffs' understanding of what they had learnt. We noted they had recruited several staff who had no experience of working in the care industry, who would be required to complete the Care Certificate to ensure they had the skills and knowledge to meet people's needs effectively.

● We looked at the induction record of a new staff member who started work six days before our visit. The care worker's induction and shadowing and observation records covering the period of 3 to 7 of February was signed off by an experienced care worker as being satisfactory for 3, 4, and 5 February only. The observation record was not fully completed and therefore there was no evidence to show what areas the new staff member required further support in. We noted the experienced staff member who, completed the shadowing, had received no training to carry out this task.

● We saw on the provider's electronic roster, the new staff member had provided unsupervised care to 11 people on 8 February 2021, even though they had not completed all the relevant essential training. We spoke with the registered manager who felt this practice was acceptable. This meant people received care and support from staff who were not always appropriately trained and assessed as competent to carry out their roles.

● The provider's training matrix showed most staff had completed all their essential learning. However, discussions with staff showed this did not truly reflect their training experience. Some of the comments from staff included, "I've completed my e-learning course with this company. I have never been physically assessed before. However, in my previous job with a different company I had both on-line training and physical assessment", "As I said, training was online and too much to take in all at once, not (received) training in the use of equipment. Never had manual handling training because of Covid-19" and "I can safely say we have had no training; we have e-learning that teaches us nothing."

● The provider's induction and training policy stated staff will be supported through mentoring and supervision for on-the-job training provided by colleagues and the registered manager. All members of staff were expected to cooperate in training newcomers. A staff member commented, "I have to train other

people using my past experience and only knowledge, no support is received."
● The provider's supervision policy stated the registered manager, or a supervisor would facilitate a formal discussion about the employee's actual performance. Staff would have six supervisions annually. Staff records showed this did not happen and the registered manager told us due to Covid-19 no formal supervisions were undertaken.

The provider did not ensure there were sufficient suitably qualified, competent, skilled and experienced staff and staff were not appropriately supported to ensure they were able to meet people's needs. This was a breach of Regulation 18 (Staffing) 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● People were not routinely supported in line with the Mental Capacity Act 2005 (MCA) and its code of practice. We asked the registered manager for evidence of how they had applied the MCA. They informed us they did not carry out any mental capacity assessments as "The social workers do this". Records indicated some people had a mental health condition, for instance dementia or an acquired brain injury (stroke) which may affect their decision-making ability. We checked care records and found no evidence of people's ability to consent to care and treatment had been considered.
● We asked the registered manager if they had needed to make any decisions in people's best interests. They told us this was always carried out in conjunction with social workers. We asked the registered manager to send us evidence of discussions held. They sent us meeting invites and a list on contacts. We were not provided with evidence of how the service met the requirements of the MCA and worked within the code of practice.
● We observed family members had signed consent forms. We found no evidence of the service seeking confirmation of third parties' legal powers to act on people's behalf. We discussed this with the registered manager who confirmed they did not request to see a copy of the legal powers held by family members. We found the registered manager did not fully understand the requirements of the MCA to ensure they protected people's rights.

This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● Providers are required to carry out an assessment of peoples' care and support needs. We viewed eight care plans and found peoples' protected characteristics as outlined under the Equality Act 2010 were not considered in any these assessments. This meant the service could not be assured staffs' working practices

would prevent discrimination and protect peoples' human rights.

● People and their relatives told us they were involved in the assessment of care and felt the service had captured their care and support needs and preferences. We were not able to confirm this in care records viewed. For instance, for us to establish what peoples' health conditions were, we had to look at what medicines they had been prescribed.

● The registered manager told us care assessments captured the care people said they wanted. Information in care records did not support this. Furthermore, staff told us they would not always know what people's care needs were before attending calls. A staff member commented, "I don't know information about people I have to work with for the first time, I get to know them only when I enter in their homes. The information on the mobile app does not tell us much. I would find out for myself by asking them questions."

● Most people we spoke with told us they had someone overseeing their food or staff would simply put in a microwave meal that had been left for them. There were, however, some instances where food was an issue. A relative commented, "I do all the shopping and they (staff) will only do microwave meals. We have had several instances where (family member) would have liked baked beans on toast or a jacket potato cut up for her, but they won't do that, microwave meals only". Whilst another relative told us their family member had been diagnosed with a medical condition which now prevented them from eating certain foods. The relative stated the person was now adjusting to this new regime of eating and alternative foods had now been prepared but, the person would forget and go out and purchase a microwave meal and staff would just give it to them without thinking of the impact this would have on them. The care records didn't reflect the change in this person's diet.

People's needs were not adequately assessed to ensure that they received appropriate care and support at all times. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Electronic records of office staff communication with health and social care professionals showed how people were supported to get access to health and social care professionals. We were unable to see the outcome of these communications and the registered manager was unable to provide us with further information during and after our visit.

●The registered manager told us they had positive working relationships with other health and social care professionals in order to get the best health outcomes for people. This was supported by a health professional who stated, "My experience of Professional Care Service has always been a good one. [Name of registered manager] in particular is dedicated to the support and care for those that the service provide assistance for. She has literally always been available to discuss any concerns or need to co-ordinate; should I be working through the week, at a weekend, in the day or evening." In contrast, a relative commented, "To be honest I just never know where I stand with [name of registered manager] and "[name of registered manager] will tell other professionals like the OT (occupational health therapist) and the social worker 'We go above and beyond for this family', and it's not true and it makes me feel bad."

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

●People were not routinely provided with person-centred care. People told us care calls were poorly planned and they did not know who was visiting them. We found some people were visited by three different care workers in one day. We discussed this with the registered manager who confirmed they did not tell people which care worker was visiting and no timetable or rota was provided to them. However, they told us people had support from the same care worker. This was not supported by what people and their relatives told us.

● Comments from people and their relatives included "We have different people coming at different times. No reliable times anywhere between 8.15am and 10.45am", "They (staff) are always different, it would be so much nicer for [name of person] if the carers were the same people, much more reassuring and doesn't seem much to ask", "We were supposed to have one girl for most of the mornings but we are getting loads of different people, never know who is coming and then you have to explain it all over again" and "We have different carers all the time".

● People and their relatives told us the care workers did not routinely stay for the allocated amount of time and the delivery of care was rushed. Comments included "We have had instances of calls being 20 minutes apart. In the first lockdown we had a time when no one visited until 1pm in the afternoon from the evening before", "In the evening they come to put the bag on, they are supposed to come around 7pm but sometimes they come at 5pm and we have to stop all supper arrangements. It's not good, we pay for half an hour but they are in and out in 15 minutes usually", "Not usually here for half an hour, usually only 20 mins", "The agency really muck us around", They never stayed half an hour, they were in and out" and "They are supposed to go for half an hour but we know they only go for a maximum of 15 minutes if lucky." One person told us they did not get the support they had agreed. They commented, "I signed the agreement for them to come in the morning at 8am and for bedtime between 8.30pm and 9pm. Sometimes they don't come until 9.45pm or 10.45pm. Some of them rush me and they don't stay for 30 minutes. I expect the treatment I want." They went on to say, "I am [xx] years of age. I should get a better service."

● We viewed call monitoring times and found this to be the case. We found care calls were not always programmed to allow enough time between visits. One person's rota routinely showed less than two hours between calls. For instance, on 7 February 2021 the tea call was planned for 4.30pm to 5pm and the bed visit planned for 6.30pm to 7pm both visits should have been for 30 minutes each. The tea call lasted 22 minutes and the bed visit lasted 18 minutes. The same person's records showed this was not a one off and in one week in February 2021 call visits were poorly spaced and care workers cut short the allocated time. Another person's records showed they received 174 mins less care than planned in one week in February 2021. We have reported this to the funding authority.

● People did not always feel involved in making decisions about their care. This was because information relating to care tasks staff had delivered was no longer accessible to them. Comments included, "The carers started off logging in with phones but apparently it didn't work so they don't do that anymore but the trouble is they don't write anything down so there is no record here (in the home) for us to see", "They (staff) do everything online, we need a book so that family can see especially as (family member) has no verbal communication so we bought a book and they write things in like 'night visit' or 'evening visit', really unhelpful" and "They (staff) used to have books to write in so family could see but now they say it's all online so no one knows anything."

The provider did not enable people to be involved in making decisions about care and people were not routinely supported as they wished. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's privacy and dignity were not routinely upheld. A person at risk due to their limited mobility and health conditions was placed at potential harm as their front door had been left unlocked by staff following their visit. This placed the person at risk of harm.

● One person had informed us they had an unauthorised visitor to their home. A care worker had taken their boyfriend into the person's home whilst on a care visit. The person had not authorised this visit and only became aware as their own family member found the stranger in the home. We discussed this with the registered manager, and they informed us disciplinary action had been taken. The staff member's disciplinary record confirmed this.

● A healthcare professional informed us they observed staff providing care and support to a person. They told us the person was not covered to protect their dignity and it was clear they were left cold whilst care workers supported them.

● People and their relatives told us they were not always treated with dignity by the registered manager. One person told us they had been called an extremely offensive name by the registered manager. A relative informed us the registered manager also called another family member a derogatory name.

● Prior to the inspection we had received concerning information about staff use of a social media platform. We received allegations the registered manager was using offensive language to describe people on social media. We found care records referred to a person expressing their dissatisfaction with a care worker who had taken photographs of their home on their phone against their wishes.

● We found, from the general feedback received from people and those who represented them about the lack of timely calls, continuity of care, and the negative impact of the registered manager's behaviour towards them, people were not treated with dignity and respect all times.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that people's privacy and dignity was maintained. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; 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, End of life care and support

- People's care records did not always include all information relevant to their care to enable staff to provide person centred care. People and their relatives told us they were able to discuss their preferences for care and support with the service before the care package began. We asked the registered manager where pre-admission assessments, which recorded this information, were located. They told us gathered information would be directly inputted into peoples' electronic care plans. There was no information about peoples' likes, preferences, social interests or family histories in all electronic care plans viewed.
- Peoples' wishes and preferences for end of life care were not recorded and considered. There was no information relating to end of life care documented in all the care records viewed. Some staff told us they had provided care to people who were at the end stages of life and training records confirmed they had attended the relevant training. However, we could not be assured that staff had all the information they needed to provide appropriate care and support that met people's needs and preferences.
- People and relatives gave mixed responses about whether reviews of care and support needs took place. Comments included, "They (management) do, they are very attentive. We had a review I think, someone from the office rang us up, about six months ago", "Yes, yeah. Review, I don't know. I don't think the supervisor has been here. I haven't had a questionnaire", and "I think they (staff) do, but sometimes she (registered manager) has to come, she (registered manager) sits down and is weary." We saw no evidence of any reviews of care and the registered manager was unable to provide us with this information during and after our visit.
- Most of the people we spoke with had female staff who provided their care and support, and this was their preference. However, one person stated they would have preferred a male carer but, "It really isn't important." The provider had not considered this preference.
- The service was not always responsive to peoples' needs. For instance, a relative, when talking about their family member who was non-verbal, said the registered manager had assured them their family member would have regular care staff who would get to know them and understand their needs. The relative stated, this had not happened but instead they had many different care staff. They told us, "She is now so depressed that she won't get dressed in the morning."

People were not routinely provided with person-centred care. The provider failed to ensure people's individual preferences and care needs were reflected in care plans and met. Reviews of care did not ensure the care and support delivered still met people's needs. This was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care records documented whether people had any physical disabilities, impairments or sensory loss but not how staff should support them. Care staff gave examples of how they met people's communication needs. We were told about a person who had a speech impediment but there was no information in their care plan to reflect this, as well as how the person preferred to be communicated to.

We recommend the service seek advice from a reputable source about how to apply the AIS and meet people's communication needs.

Improving care quality in response to complaints or concerns
● People said they knew how to raise a complaint. Comments included, "If I have a problem I would just phone [name of registered manager] at the office and they always phone back and sort it out", "We have told them (management) they come too early in the evening and so they don't do it often now but sometimes they still do", "I phone the office, not sure they listen but that's the way I raise any issues" and "The registered manager doesn't listen to issues or concerns."
● The provider had a complaints, concerns and compliments policy and procedure dated January 2019. We looked at the service's complaints register and found the registered manager did not routinely record actions taken as a result of concerns raised about care provided. They told us "If it is trivial, I will not record it, I just deal with it." This action was not in line with the complaints policy which stated, "A full record will be held of all complaints and concerns received regardless of the level of seriousness and means of communication."
● The registered manager failed to assess whether concerns raised should be reported to appropriate authorities for investigation. For instance, in January 2021, a person raised a concern that they had been mistreated by a member of staff. When discussing this concern with the registered manager they had concluded the concern was 'trivial' as the person did not like the staff member. The response to the concern was to stop the staff member from attending the person's home. This was not treated as a safeguarding concern or reported as such and therefore had not been dealt with appropriately. Care records showed by February 2021 the staff member had recommenced providing care to the person. There were no records to show the person was satisfied with the decisions the registered manager had made. We reported this incident to the local authority.

The registered manager demonstrated a lack of understanding about how to manage concerns raised. We found the provider did not operate an accessible system for identifying, receiving, handling, and responding to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- People and staff told us about their concerns about the culture of the organisation but felt unable to share this with the provider for fear of repercussions. There was a lack of confidence in the registered manager's ability to run the service. However, the provider did not have an impartial platform where people and staff could raise these concerns.
- Feedback from people and relatives included, "Quite frankly the owner of the company is not fit to be a business owner. She takes it all personally and does not take the patients' perspective", "The manager is sometimes okay and sometimes not, she is a bit moody", "They don't care. She (registered manager) is only interested in the money" and "You can't get a sensible conversation from the owner. She has no interpersonal skills, not what you would accept." "[Name of registered manager] isn't bothered… She can be very rude", "I found the manager, [name of registered manager] to be quite aggressive", [Name of registered manager] is really intimidating and can be defensive and evasive" and "No, I wouldn't recommend the agency."
- People, their relatives and staff told us they were fearful of repercussions if they raised concerns. Comments included, "Not approachable only when it suits her", "I would say, greed has definitely got the better of her. If something doesn't go her way, she (registered manager) can be very spiteful" and "Discipline treatments depend on if [name of registered manager] is angry or not."
- The provider failed to ensure records relating to service users were accurate and reflected their needs. We found improvements were required in records relating to service user's care and treatment, medicine administration records, staff recruitment records, induction and observations records and the management of the service.
- Staff told us they did not have access to previous daily notes. This meant they had to rely on their own communication methods to understand what support had been previously given to people. The registered manager told us a new electronic care planning system had recently been implemented to address this issue however, as this had recently been introduced, we were unable to assess its effectiveness.
- The provider's electronic medicine administration record which staff used when they administered medicines was not completed in line with current best practice and guidance. This was because staff only had to document they had administered medicines from a dosset box. There was no record on the mobile app staff used to show all the names of the medicines that had to be administered, whether they were in a dosset box and why they had to be taken.
- Quality assurance systems in place were ineffective. They had not identified the concerns we found.

Where information was gathered, the provider failed to analyse this to establish if there were any pattern or trends and use their findings to drive improvements.
● The service did not conduct audits of care records, medicine administration records, and staff recruitment records. Therefore, they had not addressed risks that could cause significant harm to people. It is the responsibility of the registered provider to operate systems that effectively monitor, assess and improve the quality of the service to ensure people receive safe and appropriate care.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
●Most people said they were not asked for feedback on the care provided. Where this did happen a relative explained, "We get forms to fill in at least every year about the care and what we like and don't, I just fill them in and send them back. Don't hear anything else but that's okay."
● People provided feedback about the service. Comments included, "[Name of registered manager] is really intimidating, it took me a lot of bottle to say enough is enough", "[Name of registered manager] is the manager and she's not helpful, she is just not interested," "I am courteous and polite and [name of registered manager] will be very defensive and evasive. To be honest I just never know where I stand with her" and "I can't see that they can improve much." Whilst other comments included, "So far, so good", "They (staff) do an okay job.", "Overall care is good", "They (staff) do the job", "They (staff) do well at everything", "It all flows smoothly", "I like the carers" and "I will always speak to the (registered) manager if I need to."
● The provider did seek the views of staff but there was no analysis of the information gathered to drive improvements. There were no systems in place to enable the provider to communicate how feedback has led to improvements. Some staff felt they could provide feedback and it would be acted upon. However, most staff expressed concerns about not getting their rotas in a timely manner. They told us the registered manager would send the rota as late as 10pm the night before, therefore they were unable to plan for work and their personal lives. Staff said this made them feel undervalued. Other comments from staff included. "The (registered) manager doesn't listen. She pretty much does what she feels is best. I would say, greed has definitely got the better of her. If something doesn't go her way, she can be very spiteful, taking away work from you and shortening your day. With the pandemic going on, I have discussed the problem with going into different areas, but it always falls on deaf ears. She has a way of making work become your top and only priority", "[Name of registered manager] is not approachable only when it suits her, very spiteful does not listen" and "I feel that if I talk about something (a concern) the (registered) manager does not want to hear and it could be held against me. This could come in the form of having days off, given little or no hours then being loaded up with double days, so your weekly contracted hours have to be completed in two or three days."
● There was little or no evidence of the provider evaluating learning to improve care and the management team did not understand the principles of good governance.

The provider did not actively encourage and appropriately respond to feedback about the service to allow continuous improvement. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● It is a legal requirement for providers to notify the Commission without delay when incidents happen whilst services are being provided. We found the provider had not routinely ensured all notifiable events had been reported.

This was a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

● It is a legal requirement for providers to submit their Statement of Purpose (SoP) to the Care Quality Commission. A SoP describes what you do, where you do it and who you do it for. This must be submitted when you register as a provider, make any changes or vary your conditions of registration. We found there were changes in management structure of the organisation, but the registered manager had not informed us.

This was a breach of Regulation 12 (Statement of purpose) Care Quality Commission (Registration) Regulations 2009

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
● Providers are required to comply with the duty of candour (DoC) statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.
● The service did not always comply with the DoC. For instance, a relative told us, "In January (2021) one carer was rough with (family member) and rubbed all the skin off her leg, it was a big problem. I did complain to the office and they didn't apologise but she didn't come anymore. I don't know what happened, they just said "You won't get her again."

The provider had failed to implement a system for responding to incidents in an open and transparent way. This was a breach of Regulation 20 (Duty of candour) Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose How the Regulation was not being met. There were changes in the management structure, but service failed to update their Statement of Purpose and notify the Commission. Reg.12 (2)

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the Regulation was not being met. The provider had not routinely ensured all notifiable events had been reported. Reg. 18 (1), (2) (a)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the Regulation was not being met. People's needs were not adequately assessed to ensure that they received appropriate care and support at all times. The provider did not enable people to be involved in making decisions about care and people were not routinely supported as they

wished.

People were not routinely provided with person-centred care. The provider failed to ensure people's individual preferences and care needs were reflected in care plans and met. Reviews of care did not ensure the care and support delivered still met people's needs.

Reg. 9 (3) (a), (b), (d).

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the Regulation was not being met. General feedback received from people and those who represented them about the lack of timely calls, continuity of care, and the negative impact of the registered manager's behaviour towards them, showed people were not treated with dignity and respect all times. Reg. 10 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the Regulation was not being met. The registered manager did not fully understand the requirements of the MCA to ensure they protected people's rights. Reg.11 (1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints How the Regulation was not being met. The registered manager demonstrated a lack of

understanding about how to manage concerns raised. We found the provider did not operate an accessible system for identifying, receiving, handling, and responding to complaints.

Reg. 16 (1), (2).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the Regulation was not being met. The provider's recruitment services were not robust and therefore did not protect people using the service from unsuitable staff. Reg. 19 (2)

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the Regulation was not being met. The provider had failed to implement a system for responding to incidents in an open and transparent way. Reg. 20 (1), (2) (a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the Regulation was not being met. Staff were not effectively deployed to ensure they could safely meet people's care and support needs. The provider did not ensure there were sufficient suitably qualified, competent, skilled and experienced staff and staff were not appropriately supported to ensure they were able to meet people's needs.

Reg. 18 (1), (2).

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 How the Regulation was not being met. The provider failed to ensure people were protected from avoidable harm. Risk assessments were not routinely completed to mitigate risks. We found poor medicine management. Reg 12 (1) (2)

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the Regulation was not being met. The provider had failed to implement effective systems to safeguard people from the risk of abuse. Reg 13 (1) (2)

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the Regulation was not being met. The provider failed to ensure system and processes were in place to assess, monitor and improve the service provided.

Reg.17 (1) (2)

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the providers registration.