Bright Care Agency

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bright Care Agency is a domiciliary care agency providing personal care to people in their own homes. The service is registered in Weston-Super-Mare, North Somerset. However, at the time of the inspection, the service was operating from premises in Northampton. This was not a registered location. Bright Care Agency was providing care to people who lived in the Northampton area.

As a result of concerns identified at our previous inspection in October 2020, we imposed conditions on the provider's registration. Conditions are used to limit, or restrict, what a provider can do. One of the conditions placed on the provider's registration meant the service should only be providing a regulated activity to one person. However, we found a further two people were receiving a service from Bright Care Agency. This meant the provider was not working in accordance with the conditions placed on their registration.

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

People's experience of using this service and what we found
People received poor quality care as there was widespread and significant failings across all aspects of the service. Bright Care Agency was not well-led and managed. There was a lack of oversight and governance. This put people's safety at risk and did not ensure people received a caring service. The registered managers had failed to address any previous shortfalls, resulting in a lack of improvement.

The registered managers did not follow safe recruitment procedures. Risks to people were not identified and risk guidance was not in place in people's care records. Systems to monitor and administer medicines had not improved. Infection control risks were not mitigated. Staff were not being regularly tested for COVID-19 in line with guidance. People were not safeguarded from potential abuse and neglect.

Staff did not receive a sufficient induction or consistent supervision to enable good quality care practices to develop. Staff had completed training. However, this was not always received before delivering care or in line with published guidance.

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; the policies and systems in the service did not support this practice

People did not always receive a caring and person-centred experience. We received mixed feedback about how staff cared for people. Care records did not always contain full information around communication, equality characteristics and people's interests. People did not always have a care plan.

Complaints were not identified or responded to. The provider had failed to display their current CQC performance assessment. Notifications were not always submitted to CQC as required.

The provider had a disregard for legislation and guidance and had failed to adhere to the conditions on their registration. There was no required insurance in place which put people and staff at risk. Action had not been taken from previous inspections to progress and monitor improvements.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 30 November 2021) and there were multiple breaches of regulation. Following the inspection, CQC took enforcement action.

Why we inspected
This inspection was carried out to check, if improvements had been made and the provider was working in accordance with conditions placed on their registration.

We have not found any evidence the provider has made improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bright Care Agency on our website at www.cqc.org.uk.

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 had identified seven repeated breaches of regulation and a further five breaches at this inspection. This demonstrated significant and widespread failings.

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.

At the last inspection it was recognised that the provider had failed to display their performance assessment rating and continued to do so after this was reported. This was a breach of regulation and we issued a fixed penalty notice in March 2021. The provider accepted a fixed penalty and paid this in full.

Follow up
We will continue to follow our enforcement procedures.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

Bright Care Agency

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 conducted by three inspectors.

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 two managers 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
This inspection was unannounced.

Inspection activity started on 8 November 2021 and ended on 22 November 2021. We visited the registered office in Weston-Super-Mare on 8 November 2021. We visited an office site in Northampton on 15 and 16 November 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from external sources. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
The provider was not operating from their registered location in Weston-Super-Mare. Therefore, we visited an unregistered office site in Northampton to ensure the provider had every opportunity to fully participate in the inspection.

We reviewed all information that was present. This included information relating to recruitment induction, training and supervision. We also looked at records relating to the management of the service such as governance systems, meeting minutes, policies and the management of safeguarding.

We were obstructed from viewing information in relation to staff worked hours and the management of payroll. There were no archived records available.

We spoke with three staff members and the registered managers. We visited three people who received care and support and spoke to two relatives.

After the inspection
We continued to validate evidence found. We reviewed all recruitment information.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last comprehensive inspection in September 2019, and the focused inspection conducted in October 2020, we identified the provider had failed to manage risks to people effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

● People were at risk of avoidable harm. The registered managers failed to ensure risk assessments and care-plans were always completed and accessible to staff in people's homes. For example, staff could not always access information in relation to moving and handling and health conditions. This meant staff did not have guidance about how they should reduce and manage risks to people.
● The registered managers failed to ensure people could identify who they were allowing into their homes. Staff did not always wear a uniform or carry an identity badge in line with the provider's service user guide. Comments we received included, "None come in uniform."

Using medicines safely
At the last comprehensive inspection in September 2019 and the focused inspection conducted in October 2020 the provider had failed to ensure medicines were managed safely. 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 and the provider was still in breach of regulation 12.

● The registered managers failed to identify that a person was at risk of avoidable harm in relation to a flammable topical cream. Some topical creams, although safe for application, can easily set on fire. There was no guidance available for staff about how they could lower the fire risk, for example by changing the person's clothing more frequently to prevent a build-up of cream. We spoke to one of the registered managers, who told us staff were not involved with the application of this cream. However, medicine administration records (MARs) we reviewed showed staff had applied the cream throughout October 2021.
● The registered managers failed to ensure guidance was available for staff in relation to the application of topical creams. There was no visual or written guidance on the application of creams. For example, where on a person's body the cream should be applied. This meant the provider could not be assured staff were applying topical creams in line with directions.
● The registered managers failed to ensure staff could access guidance and risk assessments in relation to

prescribed medicines, including a high-risk blood thinning medicine. Whilst the provider was not administering these medicines, there was no guidance for staff about the additional risks they presented. For example, an increased risk of bleeding and bruising. This meant staff may not know how to identify potential concerns and when to seek medical advice.

● The registered managers failed to ensure guidance was available for staff about how to administer medicines safely. One person who was being supported with their medicines by Bright Care Agency staff, did not have a care plan in place. This meant there was no clear information and guidance about how to administer the person's medicines safely. For example, there was no guidance for staff about how one medicine should be administered on an empty stomach, or that the person should avoid eating for thirty minutes after taking the medicine. This meant there was a risk staff may not administer the medicines in line with the prescriber's instructions or the product directions.

● The registered managers failed to ensure staff had always received medicines training prior to administering medicines. This meant the provider could not be assured that all staff involved with administering medicines, had the knowledge and skills to administer them safely.

● The registered managers could not be assured that staff who administered medicines were competent. This was because staff files we reviewed did not always include a completed medicines competency check. When medicines competency checks had been undertaken, they did not provide full details about when and how the staff member demonstrated they were competent and instead statements were ticked.

● The registered managers failed to ensure MARs were effective. For example, one person's MAR did not include up to date information, there was a lack of prescribing direction and no staff signature list to enable the provider to identify who had completed the MAR.

● The registered manager could not be assured their systems would identify and take action when gaps on the MAR showed. For example, we found gaps on MARS in October and November 2021 and no system of reporting and following up if people had received their medicines as prescribed.

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

● An as required (PRN) cream had a protocol in place for when this cream may be needed. This supported staff to know when a person may need this cream.

Preventing and controlling infection

At the last inspection conducted in October 2020 the provider had failed to ensure people were protected from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

● The registered managers failed to implement a COVID-19 testing programme in line with published government guidance for care home workers. We raised our concerns about COVID-19 testing with the registered managers, who were not clear about the different types of COVID-19 tests staff should take. Staff were not conducting and registering regular polymerase chain reaction (PCR) tests as required. Instead, staff were undertaking weekly lateral flow tests (LFT). Records of staff completing LFTs, were not consistent. This placed people at increased risk from the spread of COVID-19.

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

● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were somewhat assured that the provider was using person protective equipment (PPE) effectively and safely. Staff were observed to put on PPE inside the person's room rather than on entry to their home. A registered manager was observed not wearing a facemask correctly during the inspection.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed due to the lack of staff testing.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was meeting shielding and social distancing rules.

Staffing and recruitment
At the focused inspection conducted in October 2020 the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 19.

● The registered manager failed to undertake robust recruitment checks in line with guidance and the law. This meant people were at continued risk of receiving care from staff who may not be suitable to be working in care because staff who were employed, did not always have complete and satisfactory recruitment checks conducted before commencing employment.
● For example, references, full education and employment histories had not always been obtained. Two staff members' work permits had expired. Further questions requiring explanation about peoples' stated previous employment and where references were obtained they did not match the information given, had not been investigated further.
● The registered managers had not always sought information about previous roles staff had held in health and social care working with vulnerable people.
● The registered managers failed to provide us with their full employment information. This was identified at the previous inspection in October 2020. After that inspection, we imposed conditions requiring the registered managers to submit their full recruitment information. At this inspection, we found proof of identity was present. However, references, right to work checks, full education and employment information was not available to be reviewed. The registered managers were delivering personal care. One registered manager did not have a DBS check within their file and the other registered manager's DBS check was dated October 2021, when they had been delivering personal care before this date.
● The registered managers failed to work in accordance with conditions placed on their registration. At our last inspection, we identified concerns and placed conditions on the provider's registration; one condition required the provider to provide CQC with monthly updates about recruitment. The provider had failed to submit this information.
● The registered managers failed to ensure disciplinary procedures were fully followed. For example, a safeguarding concern in 2021 instigated disciplinary processes. However, these were not fully completed to achieve an outcome for the staff involved and actions to keep people safe.
● Several employees were students with limitations on working hours within term dates. There was no information of these term dates to enable the registered managers to allocate working hours in accordance with their work permit.

This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment information was better organised.

Systems and processes to safeguard people from the risk of abuse
At the previous focused inspection conducted in October 2020 the provider had failed to ensure people would be safeguarded from potential abuse or neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 13.

● The registered managers could not be assured people would be safeguarded from potential abuse or neglect due to the systems and processes in place.
● The register manager failed to investigate and manage a potential safeguarding concern in line with guidance and legislation. A safeguarding concern in May 2021 was raised with the service. Whilst one of the registered managers reported this to the local authority, it was not reported to CQC without delay. Although one of the registered managers had commenced an investigation into the concern, they failed to finish their investigation. Records we reviewed at the inspection were incomplete and did not demonstrate actions taken to protect people.
● The registered manager failed to ensure actions that were needed to keep people safe, were implemented. For example, the registered manager assessed one staff member must not support people with medicines administration due to a previous allegation. However, we found this staff member was supporting a person who had medicines administered by the service.
● People were at risk of experiencing abuse that may go unnoticed and unreported. Staff had not always received safeguarding training before they started delivering care and support. For some staff safeguarding training was conducted several months after they had begun delivering care and support to one person.
● The provider had not been open about the service users they were supporting. Therefore, we were unable to review complete information in relation to safeguarding. We could not be assured all concerns were identified and correct processes followed.
● At the last inspection there were no adequate systems to monitor the timeliness and completion of care calls. At this inspection, improvements had not been made. For one service user, the times of care calls were recorded as the scheduled time rather than the exact time staff arrived and left. A relative told us staff were, "Never on time."
● We were obstructed from reviewing further information about the hours staff had worked. The registered manager could not explain how systems would be effectively developed if more service users were supported.

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.

● Training records reviewed indicated staff had completed safeguarding training. This was confirmed by staff we spoke with. Staff we spoke with could explain how to identify and report abuse.

Learning lessons when things go wrong
● The registered managers failed to implement systems that supported learning when things went wrong. This had been highlighted to the provider at the previous two inspections.
● Shortfalls identified previously had not been acted upon to ensure improvements had been made. Repeated breaches of regulation were found.
● Records were not completely, comprehensively and accurately kept, to enable the service to identify,

reflect and improve.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At the last inspection the provider had not ensured staff were suitably skilled and trained. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was reported on in the well-led domain of the report published in November 2021.

At this inspection some improvements had been made in this area. However, the provider was still in breach of regulation 18.

- Staff had not always received an induction to ensure they were suitably qualified and skilled to carry out their roles.
- The provider's manual handling training placed people at risk of avoidable harm. Staff told us they completed practical manual handling training whilst supporting a person. One staff member said, "[I] learnt how to use hoist techniques on the person." The registered manager confirmed this and told us they were not financially able to provide practical training in a controlled environment. This meant the service was not working in line with published guidance or allowing staff to develop their practical skills and competence before delivering support.
- The provider could not be assured staff had the necessary skills to safely conduct their roles. Competency assessments to check manual handling and personal care had not always been completed. Where competency checks had been completed, they were not always dated to show when they took place. Competency checks did not detail what had been observed to enable a judgement of competency to be made.
- Following a safeguarding concern in May 2021 staff involved had not completed additional or refresher training in relevant areas.
- Staff had not always completed training in areas such as first aid, medicines, manual handling and safeguarding before they began delivering care and support.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Supervision and spot checks on staff had been conducted. However, these were not always dated to record when they took place and were not consistent for all staff members.
- The registered managers had no overall oversight of staff supervision. This did not enable supervision to be monitored or consistent.

● Since the last inspection staff had completed mandatory training and modules of the Care Certificate. This information was in staff files.
● The registered managers had an overview of training. They told us they were adding information to this to include the care certificate modules.

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.

● The registered managers failed to work in accordance with the MCA. For example, one person's care plan stated the person lacked capacity overall. Capacity had not been assessed in relation to a specific decision. When a person lacks capacity to make a specific decision the best interest process should be completed.
● Where a person lacked the capacity to make decisions, a relative had consented to care on their behalf. The registered managers failed to request proof, for example a lasting power of attorney, to be sure that the decision maker had the legal right to make such decisions.
● There was no guidance about how one person would indicate and communicate consent to care.

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

● Staff had received training in the Mental Capacity Act (2005).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider was not always working in line with published guidance. For example, around training, COVID-19 and consent to care.
● The registered manager had completed pre assessments, which involved people and their relatives. This included information on culture, religion and health conditions.
● The care plan for one person had improved in detail from care plans reviewed at the previous inspection. However, further person-centred details were required such as information about people's end of life wishes, communication and areas of interest.

Supporting people to eat and drink enough to maintain a balanced diet
● Information for one person showed the service did not support them around food and hydration. The registered managers could not be assured care was being delivered to meet two people's needs as there were no care plans.
● Pre assessment information for one person showed their preferences around food and drink and a health condition. There was no care plan. Daily records showed Bright Care Agency supported them with their food

and drink. Information had been recorded in the daily notes as to what the person had eaten and drunk.

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

- The registered manager could not be assured they provided consistent, effective care.
- One person who did not have a care plan had a health condition, which would require a protocol for staff to follow should they deteriorate. Another person without a care plan had regular visits from the district nurse. It was not clear what support they had from this team and what information would need to be observed or shared.
- The registered manager could not give clear and accurate information in relation to other agencies they had liaised with.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- The registered managers had not ensured the systems, structures and processes within the organisation ran effectively to ensure people were well treated and promoted a responsive and caring culture. Previous shortfalls identifying how care was conducted had not been addressed.
- People had been put at risk as the registered managers had not ensured people's well-being and safety was paramount. For example, by not following recruitment procedures, staff completing COVID-19 testing as required and staff induction and training.
- We received mixed feedback about staff. Some staff were complimented on their kind and reassuring nature. A relative said, "Some staff are good, they are gentle and try to create a rapport."
- However, we received other feedback which detailed staff not engaging with people, not communicating the care they were giving and not developing positive relationships.
- Staff did not always speak in English whilst delivering care and support. The registered manager had addressed an incidence of this at the time, prior to our inspection. However, it was disrespectful to the person receiving care.
- People did not always know who staff were or their names. Staff did not always have identification with them.

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

- Care plans gave limited information about how people expressed their views and communicated decisions. This is important for staff to know, to enable trusted relationships to develop.
- People did not always have a plan of care in place and therefore could not be involved in decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- Staff did not always demonstrate support in a caring and dignified way. We received feedback that staff laughed and giggled with each other whilst delivering care. This could be interpreted negatively by the person receiving care and did not demonstrate respect.
- Staff did not always make efforts to communicate and engage with people. A relative said, "Staff need to communicate with [Name of person]. [Name of staff] would just be silent." It is important staff ask, check and reassure the person whilst care is being delivered so they feel safe and comfortable.
- The cultural values and known preferences for one person in relation to their dignity was not explored in their care plan. This meant staff would not know the relevance or how to deliver care in the persons preferred way.

● People's privacy was respected. A care plan referred to how to maintain a person's privacy when delivering care.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

- At our last comprehensive inspection in September 2019 we identified improvements were required in the management of complaints. At this inspection, we found the provider had failed to act and no improvements had been made to the management of complaints.
- The registered managers could not be assured the systems in place would identify complaints or make sure they were responded to.
- Two people receiving a service did not have access to the provider's complaints procedure. The complaints procedure in another's persons home was incomplete. For example, contact information for out of hours services was not recorded.
- The registered managers failed to follow their complaints procedure. We reviewed records showing one of the registered managers had been made aware of a complaint. However, this complaint was not recorded in the complaint log and both registered managers informed us they had not received any complaints since our last inspection. There was no investigation or response to the complainant.
- The registered manager had addressed another complaint raised about staff conduct. However, this had not been followed through the complaints procedure and the complainant had not received a formal response.

This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; 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; Meeting people's communication needs

- The registered managers could not be assured they were providing person centred care. Shortfalls identified across this inspection did not support the facilitation of person-centred care.
- Two people the service was supporting did not have a care plan in their home. Staff would not have reference to guidance about how to support these people safely, meet their needs or preferences.
- The registered managers and a relative told us about the gender preference for care staff for one person. This was not documented in the care plan although it had been facilitated.
- People's end of life wishes, were not obtained during the pre-assessment or included in one person's care plan.
- There was limited information in one person's care plan about their interests, social and communication

needs. For example, one person was nonverbal. However, there was no information about how the person communicated and demonstrated different emotions and feelings.

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

- The service user guide produced June 2020 included pictorial images to aid understanding. However, the guide in one person's home had incomplete sections around fees and charges.
- The provider could not be assured people had information presented to them in a way they could understand. Pre assessment information and one person's care plan did not fully explore people's communication needs.

This was a breach of regulation 9 (Person-centred care) 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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection in October 2020 the provider had failed to operate effective governance systems, this was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17.

- We found repeated breaches of regulation which had been previously identified and further shortfalls at this inspection.
- The provider was not operating the regulated activity from the registered location in line with the conditions of their registration. We visited the registered location in Weston-Super-Mare and were informed the provider no longer had access to that address due to payment arrears.
- The provider had not ensured the confidentiality of information. Records relating to former employees and the planning and delivery of care had not been stored securely and in line with legislation and guidance at the registered location. Systems and processes did not support the confidentiality of information.
- The provider had not adhered to the conditions placed upon its registration to keep people safe following the inspection conducted in October 2020. Bright Care Agency required written agreement from CQC to accept new service users. Having approached CQC and obtaining written agreement for one service user in September 2021, at this inspection we found Bright Care Agency had been supporting this person for two months prior to the written agreement. Two further service users, one that had been declined authorisation by CQC due to a lack of assurance the organisation could meet their needs, were found to be in receipt of a service by Bright Care Agency.
- The information the registered manager had provided to CQC in respect of staff employed was inaccurate. The registered manager's records demonstrated staff who were supporting a person with personal care who had not been disclosed to CQC.
- Governance systems had not been developed since the last the inspection to be able to effectively assess, monitor and improve the service. Whilst some audits were conducted in medicines, recruitment and training, these were ineffective at identifying shortfalls. Audits did not drive change.
- Recruitment audits when completed did not identify shortfalls in required information. For example, one staff member had no references on file. The recruitment audit completed for this staff file in August 2021 was

ticked to say there were two references in place.
● The registered managers could not adhere to their COVID-19 vaccination policy as they did not have records or oversight of staff vaccinations. On review of staff vaccination information, it showed only three of thirteen staff were fully vaccinated. The registered manager told us they were supplying staff to some local care homes.
● The registered managers failed to implement a robust action plan. The plan was incomplete, had not addressed all issues previously identified from the previous two inspections and did not detail how areas were going to be effectively improved. Nor had the action plan been regularly updated or demonstrated any progress had been made.
● Records were poorly kept and maintained. Information in relation to staff recruitment, induction and competencies was often not dated or completed. The registered managers did not have oversight of areas such as supervision or staff testing.
● We were not assured the registered managers had adequate systems for calculating and monitoring hours that staff had worked. Staff signed in and out of a care call, however these records were not contemporaneous. The registered manager said they manually calculated hours. The registered managers obstructed the inspection and would not allow inspectors access to records that would show the hours that staff had worked.
● The registered managers could not be assured they were invoicing people correctly for the care provided as timesheets recorded scheduled hours of support rather than actual hours worked by staff.
● The provider had not demonstrated it could operate a safe and effective service on a minimal number of service users. The provider had not shown it could make improvements and safely develop the service to support more people.

● All providers have to pay a fee to the Care Quality Commission. The provider had agreed a payment plan with the Commission. The provider had not kept up to date with the agreed payments. At the time of the inspection the payment plan was in arrears.

Non-payment of fees is a ground for cancelling the registration of a registered provider under section 85 of the Care Quality Commission (Registration) Regulations 2009 (as amended).

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

We have referred the provider to external agencies where appropriate.

● The registered managers did not demonstrate the skills and knowledge to operate a safe and caring service.
● The registered managers did not ensure their regulatory responsibilities were fulfilled. This is demonstrated by the widespread and significant failings outlined in this report.
●The registered managers did not ensure their employer responsibilities were fulfilled. For example, by having a staff pension scheme or suitable insurance cover.
● The registered managers were not able to supply full recruitment information for themselves as outlined in the regulations at this and the previous inspection in October 2020.
● The registered managers obstructed the inspection by repeatedly not allowing inspectors to view information around staff worked hours, PAYE and payroll.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in October 2020 the provider failed to display their performance assessment rating. This was a breach of regulation 20A (Requirement as to display of performance rating) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was issued a fixed penalty notice for this breach of regulation in March 2021.

● When a provider has been given a rating by the Commission it is required to conspicuously display this at the main place of business and on their website. This is to ensure people using services or relevant others are aware of the current rating of the service and the findings of the last inspections.
● The provider had failed to display their performance assessment rating on their website and at their registered location.

At this inspection the provider had not taken any action and was still in breach of regulation 20A (Requirement as to display of performance rating) of the Health and Social Care Act 2008.

At the last inspection in October 2020 had not submitted notifications as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● Since the last inspection took place in October 2020. CQC was informed and had verified that a person using the service sustained a serious injury whilst in receipt of the regulated activity in May 2020. This is a notifiable incident and was not reported to CQC at the time or afterwards.
● The registered manager failed to send us follow up information as requested by CQC following a safeguarding notification in May 2021, despite repeated requests.

The failure to submit a notification was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider was not conducting the service in line with their statement of purpose. The service was not operating from the registered location in Weston-Super-Mare. People and relevant others would not be able to locate Bright Care Agency due to documentation showing different office locations.

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

● People and staff were at risk as the provider had no public or employer liability insurance.
● The service did not have sufficient funds to implement effective systems and fulfil regulatory requirements. The registered manager told us, "We are not financially stable."

This was a breach of Regulation 13 (Financial Position) of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Good outcomes could not be fully achieved for people as the provider lacked integrity and honesty. The registered manager had presented themselves under a different company name.
● There was not an open and honest staff culture. Staff we spoke with confirmed an inaccurate start date of one care package.
● Staff meeting minutes from 08 September 2021 recorded the registered managers discussing with staff about a new service user. However, this package of care had already commenced without written

agreement from CQC in line with the providers condition of registration.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered managers were able to explain they understood what the duty of candour meant and the responsibilities it entails.
- The provider has demonstrated to CQC they were not open and transparent. We were not assured the provider would fulfil the duty of candour regulation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had implemented surveys to gain staff feedback. However, it was not demonstrated how the information gathered was used in developing the service.
- Information was not fully gathered to inform care plans around people's equality characteristics. Such as how people's culture was reflected in their daily life.
- The public was not given complete information about the service in order to be fully engaged. For example, around the service's CQC assessment rating.

Continuous learning and improving care; Working in partnership with others

- Lessons were not learnt. There were continued shortfalls found at this inspection.
- Actions had not been taken to ensure improvements were made.

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 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had failed to operate in line with their statement of purpose. Regulation 12 (1) (3)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 13 Registration Regulations 2009 Financial position except health service bodies and local authorities The provider had failed to ensure the financial viability of the service. Regulation 13 (1) (1a)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured notifications had been submitted as required. Regulation 18 (1)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the requirements relating to registered managers had

	been fulfilled. Regulation 7 (1) (2) (a) (b) (d)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to obtain consent lawfully. Regulation 11 (1)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people had accurate and sufficient risk assessments in place to provide safe care and support. The provider had not ensured the safe management of medicines. The provider had not ensured risks from infections were controlled and reduced. Regulation 12 (1) (2) (a) (b) (c) (g) (h) (i)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from abuse. Regulation 13 (1) (2) (3)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effective systems to identify and handle complaints. Regulation 16 (1) (2)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that adequate systems were in place to review and monitor the quality of the service and ensure robust systems were in place to provide good, consistent and safe care. Regulation 17 (1) (2) (a) (b) (c) (d)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate recruitment procedures which ensured fit and proper persons were employed. Regulation 19 (1) (a) (b) (2)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed their performance assessment rating on their website on in their office location. Regulation 20A (1) (2) (5) (7)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The provider had failed to ensure the requirements relating to registered managers had been fulfilled. Regulation 7 (1) (2) (a) (b) (d)

The enforcement action we took:

We took action to close the service

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure people were supported by staff were competent and skilled. Regulation 18 (1) (2) (2a)

The enforcement action we took:

We took action to close the service