Professional Care Services Bucks Limited

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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 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 51 people.

People's experience of using this service and what we found
People continued to be supported by an inadequate service. The registered manager and provider had failed to act on our previous concerns. The registered manager had employed a consultant to help drive improvement, however, the support provided was ineffective and did not have a positive impact or ensure the required improvements were made.

The service was not consistently well led. The registered manager was unable to demonstrate they were able to run a regulated service. We had major concerns about their conduct and treatment of people, their relatives and staff. We found the registered manager had described people as "Idiots" and routinely described people as their medical condition. For instance, they often referred to people as "Mental Health". In meetings with the local authorities the registered manager described staff as "awkward".

People and their relatives told us, "[The owner] took things a bit too personally and "She's just a bad manager".

People and their relatives told us the service was very poorly run. They described the service as "shambolic". Other comments included, "They're ill mannered, [the people in office], some of them. You can never get anybody high up [in the office]. I can never get in touch with anybody to speak to [about my concerns]" and "They have bad management."

People were placed at risk of harm and abuse. The registered manager and provider failed to ensure risk assessments were completed. The management team and staff lacked understanding about safeguarding thresholds and failed to report events to the local authority.

People were placed at risk due to poor recruitment and training of staff. The registered manager and provider failed to ensure all the required pre-employment checks were completed. Staff were supporting people without the minimum training. One staff had been in post since 25 May 2021 and they had only completed three on-line training courses. They had been supporting people with prescribed medicine without any training or competency training.

The registered manager and provider did not have effective systems in place to manage complaints. At the inspection the registered manager asked office staff "Who deals with complaints".

People did not have care plans which reflected their preferences. People were not routinely treated with dignity and respect.

The registered manager and provider failed to ensure they were open and transparent when care was not delivered as planned. The registered manager failed to make all the required statutory notifications to the Care Quality Commission, when required.

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.

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 12 April 2021) and there were 12 breaches of the regulations. We issued urgent enforcement action to prevent the provider from taking on additional people. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of multiple regulations.

This service has been in Special Measures since the last inspection and remains in special measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. Since the last inspection we have continued to receive concerns about the management of the service. We received no reassurance from the provider the required improvements were being made.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Professional Care Services Bucks Ltd 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 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.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We identified ongoing breaches of the regulations and we considered escalating our enforcement powers. This could have lead to cancellation of their registration or to varying the conditions of their registration.

We worked closely with the provider and were honest about the level of concern we had about people's safety. The provider informed us they wished to cancel their registration with us. They have now applied to cancel their registration and will no longer be providing support to people.

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 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 an inspection manager. They were supported by two Experts by Experience who 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
The service is a domiciliary care agency. It provides 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
This inspection was unannounced.

Inspection activity started on 1 July 2021 and ended on 8 July 2021. We visited the office location on 1 and 2 July 2021. The Experts by Experience made telephone calls to people and their relatives on 6 July 2021. An inspector contacted staff on 7 July 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service.
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. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and 14 relatives about their experience of the care provided. We spoke with the registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. In addition, we spoke with 11 members of staff including the, assistant manager, care manager and care staff.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We held meetings with the provider and the local authorities.

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 now remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our inspection in February 2021 the registered manager and provider had failed to assess the risks to the health and safety of service users receiving care or treatment. They failed to do all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider completed an action plan and had routinely told us in communication they would make changes to meet this regulation.

At this inspection we found continued breaches of Regulation 12. We found people continued to be put at risk of poor management and potential harm.

- People were not routinely and effectively protected from avoidable harm. We found the provider had failed to ensure they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required.
- We found people who were at risk of self-harm had no risk assessment or escalation plan in place to give clear direction to staff to help them manage allegations or threats of self-harm. One person reported to staff they wanted to take their own life on 4 June 2021. A staff member had recorded they had spoken with the person about support groups they could join. No other action was recorded. We spoke with the registered manager who told us they had contacted the mental health team. No records were made of this contact. The same person had previously attempted an overdose on 21 April 2021. The registered manager was aware of this risk, but failed to mitigate it or provide guidance to staff. This placed the person at ongoing risk of harm.
- Another person had informed staff they wished to take an overdose of their medicine on 27 April 2021. No risk assessment or escalation plan was in place to guide staff on what to do when these allegations were made. No contact was made with external healthcare professionals to advise them of the person's state of mind. We found the registered manager had failed to take appropriate action to mitigate this risk.
- Risk assessments were completed for skin integrity; however, the level of risk was not routinely assessed accurately. One person's care plan stated, "I have a high risk of skin problems as I have broken skin on my legs which I have cream prescribed for". However, their skin care risk assessment stated they were at low risk and had "healthy skin". In addition, the scoring on the assessment did not reflect the person's medical condition which would have increased their risk score.

We found the provider had not addressed our previous concerns about the management of risk and systems were not in place to ensure people were protected from potential risks. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Using medicines safely

At our inspection in February 2021 the registered manager and provider had failed to ensure people were supported with their medicines in a safe way. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found continued and repeated breaches of Regulation 12. People continued to be put at risk as a result of poor medicine management

● People were put at continued risk of either not receiving their prescribed medicines on time or risk of overdosing. This was because the registered manager and provider failed to ensure staff had access to accurate records relating to people's prescribed medicines. Care calls were not planned to allow enough time between each care visit to ensure people were safely supported with their medicines.
● One person had a "Medication Risk Assessment" dated 17 March 2021. This listed their medicines. However, it failed to list all the person's prescribed medicines. We found the person was routinely given Gabapentin 300mg two capsules, three times a day and Paracetamol 500mg two tablets, four times a day. These were listed on their medication risk assessment. This record also contradicted the person's care plan. This had the potential to cause staff to administer the wrong medicines which had the potential to put the person at risk of harm. We found other records which did not reflect people's prescribed medicines and found staff had routinely administered medicines which were not listed on the "Medication Risk Assessment".
● One person was placed at risk of overdosing on prescribed pain relief as care calls were not spread out to ensure they received pain relief in safe timeframes. The person's care plan stated, "Also make sure there has been at least 4 hours between the last batch of medication because of his Gabapentin and Paracetamol." We found this was not routinely the case. On 30 June 2021, the person was given two Gabapentin 300mg capsules and two Paracetamol 500mg tablets at 12.07pm and again at 15.38pm. This was a gap of three hours and 31 minutes which placed them at risk of an overdose. On 25 June 2021 care calls were poorly planned, the evening call was planned for 17.50 and the bedtime call for 20.45. Records showed the person received two Gabapentin 300mg capsules and two Paracetamol 500mg tablets at 20.50 and 22.56 this was a gap of two hours and 56 mins. The recommended minimum time which should be given between doses is four hours. The person had a history of overdosing with prescribed and over the counter medicines. The poor planning of care visits contributed to potential harm and possible overdose of medicines.
● People did not always receive their prescribed pain relief when needed. Care calls were not programmed to allow enough time between calls to ensure staff could administer medicines. On 30 June 2021 a member of staff had recorded "Too early for meds". The teatime visit had been planned for 17.40 and the bedtime call for 20.35 a gap of two hours 55 minutes. This placed the person at risk of not receiving prescribed pain relief and therefore had potential to affect their well-being and quality of life.
● People who were prescribed medicine for occasional use or "as required" were supported by staff who had no additional guidance on the maximum dosage or duration in between doses. This is against National Institute for Health and Care Excellence guidance (NICE NG67), which stated "The maximum number of doses to be given (for example, in a 24-hour period)" should be recorded.

We found the provider had not addressed our previous concerns. 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 continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our inspection in February 2021 the registered manager and 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.

At this inspection we found people were placed at continued risk of abuse. The registered manager failed to recognise potential abuse and report it to the local authority.

● People continued to be placed at risk of harm and abuse. Since the last inspection the CQC has made 23 safeguarding referrals to Local Authorities following concerns raised with CQC or evidence found on inspection. We found a further four incidents on inspection of the service, the assistant manager confirmed they had made safeguarding referrals to the local authority after we discussed our concerns with them.
● The registered manager demonstrated a clear lack of understanding and knowledge of the safeguarding thresholds. We found four incidents which met the safeguarding threshold; however, the registered manager had prevented the assistant manager from referring the incident to the local authority as they felt the threshold had not been met. When justifying one event they described the care worker's behaviour and treatment of the person as "cultural" The records showed the person had been visibly distressed and was observed to be crying following the interaction from the staff.
● Staff had not always undertaken safeguarding training. One member of staff had been in post since 25 May 2021 and they had not had any safeguarding training.

The provider and registered manager failed to ensure people were protected from potential abuse. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our inspection in February 2021 the registered manager and 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 we had ongoing concerns about the recruitment of staff, the support they received to ensure they had the right skills and attributes and how rotas were managed.

● The registered provider and manager failed to ensure they had robust and safe recruitment practices in place. This meant people were at continued risk of being supported by unsuitable staff. We found recruitment records were either incomplete, contradictory or failed to meet with requirements of the regulations.
● One staff members recruitment file had two application forms. Their employment history stated they had provided personal care for an individual for three and a half years, however, the reference from the person's relative stated that they had provided care for five years. This had not been picked up during the recruitment process. The staff member had also mentioned in one part of their application they were currently providing support for 'two people with disabilities at present'. There was no further information about this, it was not included in their employment history, there were no referees in relation to this post and the provider had not explored this with the applicant.
● We found the service failed to explore gaps in employment history with new staff. One member of staff had

completed an application form in February 2021. Their last recorded employment was August 2020, there were no records to show the gap in employment had been explored. One reference for the same member of staff had been written by an employee of Professional Care Services Bucks Ltd who was their friend. We also noted the same staff member's criminal record check (DBS) was from a previous employer that was not listed on their application form. Other checks required for new staff were also not completed. For instance, the service failed to confirm one member of staff's right to work in the UK.

We found reasonable steps had not been taken to ensure staff were suitably recruited. This placed people at risk of not being supported by people who had the required pre employment checks in place. 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 our inspection in February 2021 the registered manager and provider had failed to ensure staff were effectively deployed to 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. Which we reported under the effective domain in the last report

At this inspection we found ongoing concerns about the deployment of staff. We found care visits were poorly planned.

● Records showed people did not always have routinely planned visits at the time they expected them. We routinely found people's calls were planned too close together. Staff told us the rota was "Not great" and felt people did not get the calls they should. One member of staff told us "The rota is rubbish, I have tried to tell them, but I have now given up".
● People and their relatives said the poor management and planning of care visits put them at risk. One person who attended an important weekly medical appointment with their relative told us, "I am worried [name of person] has not got ready in time for when the ambulance arrives to take him…The stress of late carers is not good for him or for me." Another relative told us the staff "Have come very, very late so one of my girls from the doctor's surgery has popped in and got him ready."
● Other comments about timings of calls included, "They have been very nice but there were about five or six times when they haven't come on time and we have been waiting" and "No, we had agreed initially 8.00-9.30am and 12-13.00pm. The morning call would be 11.15am and the lunch time could be 11.45am, way too close together and sometimes they would cross over. More often than not the morning would be 20 minutes – half hour and the other three calls on average 10-12 minutes, 15 minutes at the most." The person's care plan stated they should have three 30 minute calls a day.

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

Learning lessons when things go wrong

At the last inspection evidence under this key question contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which we reported under the well led domain.

At this inspection we found the provider and registered manager had not made improvements on learning lessons when things went wrong.

● People were not supported by a service that responded to accidents and incidents in a way that they

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.

The provider and registered manager had not ensured systems or processes were in place to learn lessons when care was not delivered as planned or went wrong. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our inspection in February 2021 the registered manager and provider had failed to implement effective systems to safeguard people from the risk of contracting Covid-19 and other infectious diseases. 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 we found people some improvements had been made, however, feedback from people was mixed about staff compliance with wearing personal protective equipment (PPE).

● We found office staff were adhering to current government guidance. We observed them wearing the level of PPE required. However, the registered manager was routinely seen removing their face mask whilst in the office and within close proximity to other staff.
● People and their relatives gave us mixed feedback about the level of staff members compliance with the requirements for wearing PPE. One person told us "This one girl came in in the middle of Covid-19. She came with no PPE on. We didn't have vaccines then. I told her she is not coming in without proper PPE and she said it was in the car. I told her to go and get it." Another person told us "One girl, I don't know who she was, but she was not wearing a mask and it was deep in the pandemic". More positive comments included, "They wear masks and gloves, but I wouldn't let them in if they didn't".

We recommend the provider and registered manager seek guidance from a reputable source on ensuring compliance with national guidance on infection prevention and control.

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 now 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our inspection in February 2021 we received feedback from people, their relatives and staff about the registered managers conduct. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We previously reported this under the caring domain.

At this inspection we found ongoing concerns about the registered manager's conduct, communication and treatment of people and their relatives.

● People were not routinely treated with dignity and respect. The language used by the registered manager to describe people did not demonstrate they understood how to treat people with dignity. In the meetings we had held with them and the local authorities the registered manager used generic terms or people's conditions to describe them. For instance, in one meeting the registered manager kept referring to a person as "mental health". In another meeting they had described staff as "awkward" This was addressed with them at the time and they were asked to reflect on how they communicated.
● An ex member of staff had shared copies of social media messages which they had been sent from the registered manager. The message was verified as being sent from the registered manager's phone. In the message they described service users as "Idiots" and described the local authority electronic monitoring system as "[a very derogative word]". We asked the registered manager to explain the messages. They denied all knowledge of the messages and provided an inappropriate and irrelevant response.
● Daily notes written by care staff and care plans written by office staff; did not routinely demonstrate they knew how to promote dignity in people. For instance, we found office staff had recorded on 7 June 2021 they had "Called and left message for D/N Team to call back in regard to (name of person) bum sores." One-person care plan stated, "Open the pad and then use the dark flannel to wash the pad area." A care worker had recorded in daily notes they had "done her feet". We found daily notes written by staff routinely referred to tasks completed rather than how the person had been supported.
● There was an extremely poor culture within the service. People and their relatives were disparaging about the management of the service. More than one person described the management as "shambolic" or a "shambles". Other comments described the registered manager as having an "unreasonable attitude".

The provider failed to ensure the registered manager demonstrated good leadership skills and treated

people with dignity and respect. This was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in February 2021 the registered manager and provider had failed to ensure staff were effectively deployed to 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. We previously reported this under the effective domain.

At this inspection we found people continued to be placed at risk of harm by being supported by staff who had not received adequate training and supervision.

● People were routinely supported by staff who the registered manager failed to ensure were suitably qualified, competent and experienced to provide safe care and treatment to people.
● Staff did not have appropriate support, training supervision and appraisal necessary for them to carry out their role. We were not satisfied with the reasoning behind the lack of evidence about how the registered manager supported staff. One member of staff had commenced employment on 25 May 2021. To date they had undertaken fire safety, first aid, moving and handling training. However, they were routinely supporting a person who needed full assistance with the administration of their prescribed medicines. The member of staff had not been assessed as competent to support people with medicines. The person was identified as at high risk of self-harm through overdosing on medicines.
● People told us, and this was supported by staff comments, new staff had not always received training to use equipment used to help people move positions. For instance, one member of staff supported a person who required the use of hoist to support them move positions. The member of staff had only attended an online theory of moving and handling training course and no competency assessment had been completed on their ability to use equipment. Another staff member told us the same staff was unsure how to use the hoist in a person's home. One relative told us staff, who had visited their husband to help him move positions, did not know how to use the hoist and they had to show the member of staff how to safely use it.

The provider and registered manager failed to 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 continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our inspection in February 2021 the registered manager and provider had failed to ensure effective systems were in place to manage a safe service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found ongoing concerns about the management of the service and continued multiple breaches of the regulations

● People were supported by a service that was not well-led. There was a clear lack of knowledge and skills to run a regulated service. Systems were either not in place or effective to manage a safe service. We found the provider and registered manager had not taken on board our previous concerns. The nominated individual, who the provider had employed to support the required improvements, told us they had attempted to implement systems to drive improvement, however the director and registered manager had been reluctant to accept the changes.

● People told us, "[The service is] bloody poor! They come and they go as quickly as they can get away. Sometimes they don't wash up. It's a rotten service."
● We found people's records were either incomplete, inaccurate or contradictory. The registered manager told us they used an electronic oversight tracker to record all accidents, safeguarding, concerns and telephone calls. However, we found this was not the case. Where concerns had been raised about people's health, we found no records existed for what action had been taken. The last recorded safeguarding event on the oversight tracker was the 21 May 2021, however the service had referred a safeguarding concern to the local authority on 22 June 2021.
● Accidents and incidents were not analysed to identify any trends in order to prevent a re-occurrence.
● The registered manager was unaware of roles and responsibilities within the organisation. When asked about what they expected staff to undertake they were vague, non-committal and were unable to provide a response.
● The registered manager failed to act on feedback given to them. Since the last inspection the CQC along with two local authorities have met with the registered people and senior management team members. At no time throughout the meetings has the service offered the required assurances improvements were being made. In one meeting the nominated individual and registered manager asked, "What is it you want".
● At the previous inspection we found 10 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulation 2009. At this inspection we continued to find breaches of multiple regulations.

We found people were placed at continued risk of harm as effective governance arrangements were not in place. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in February 2021 we found the provider and registered manager failed to inform us of all reportable events. This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found continued breaches of this Regulation.

● Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We found four events which should have triggered a safeguarding referral to the local authority and a notification to CQC. We checked and neither had been completed.

This was a continued breach of Regulation 18 (Notification of Other Incidents) of the 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

At the inspection in February 2021 we found the provider and registered manager 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

● 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 provider had a 'Duty of Candour Policy and Procedure' dated January 2019 and reviewed in March 2021. This laid out the requirements of the regulations. However, when we asked the registered manager to confirm what action had been taken when mistakes occurred, they were unable to demonstrate how they followed the policy or met the requirements of the regulations.

This was a continued breach of Regulation 20 (Duty of candour) 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; Working in partnership with others; 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.

At the inspection in February 2021 we found the provider and registered manager failed to ensure people were supported in line with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found ongoing concerns people were not being supported to make informed decisions about their care and were placed under restrictive care which had not been assessed as in their best interests.

● People were not routinely protected to have their human rights upheld as the management team and staff had a lack of understanding and knowledge about mental capacity, levels of authority and awareness of the code of practice.

● People were given covert medicines without any authority or assessment of their mental capacity or referral to an external healthcare professional. One person's care plan stated "The husband deals with (name of person) medication but asks that we crush the medication into (name of person) porridge in the morning. The medication will be left on the kitchen side. When you have made the porridge, put the big tablet in first and this will start to dissolve with the heat of the porridge, mix this in crushing it as you go, and it will eventually dissolve almost completely. Then add the rest of the tablets, do not put the capsule in. Feed this on the first spoonful of porridge."

● Another person's care plan stated, "Do not give (name of person) the choice of which meal to have, just make a hot meal and put it in front of (name of person)". No mental capacity assessment had been written for them.

The registered manager and provider lacked understanding and awareness of the requirement to support people to make decisions. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the inspection in February 2021 we found the provider and registered manager failed to ensure people's needs were adequately assessed so 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.

At this inspection we found ongoing concerns people were not receiving person centred care.

● People's care plans were not routinely person centred. One person's care plan dated 23 June 2021 was incomplete, the following sections were not completed. "Things You Need To Know", this section should have contained, information about the person, their religious and cultural needs, any allergies and any medical conditions. There was also an uncompleted section about any high risks the person was exposed to. The person was at high risk of self-harm. This was not detailed in their care plan.
● Care plans were completed by office staff who had telephoned next of kin to complete paperwork. We had previously shared our concerns about the registered manager's approach to assessing people's needs. However, it was clear this continued to be a paper-based exercise, rather than a full assessment of need based on collaborating with the person. For instance, we found office staff had recorded on 20 May 2021, "Phoned (name of relative) to ask him a few questions about (name of person) for the Person-Centred Full Needs Assessment Form". The office staff member had no training on assessment of need.
● People told us they were not happy with the service they received, comments included, "I have had some rotten ones (carers)…. I've been very ill. One of [the carers] walked out when I was being sick (vomiting)", "One helper comes and sits on the arm of the chair. I've told her not to do it. She's a rude person" and "I have one carer that's absolutely fantastic, but the rest are dreadful…. For the next two days and in the afternoon, I've got a dreadful carer. They're not shown what to do. They're thrown in at the deep end. I can't get out of bed and go to the kitchen to show them which [appliance] is the kettle".

The lack of collaborative assessment of need with the person demonstrated a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At the inspection in February 2021 we found the provider and registered manager failed to ensure they responded 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. We previously reported this under the Responsive domain at the last inspection.

● The registered manager failed to ensure complaints were investigated and followed up. On day two of the inspection the registered manager asked the office staff "Who deals with complaints." When we pointed the lack of knowledge out to the registered manager, they were unable to tell us who they expected to deal with complaints. We asked the registered manager for evidence of how complaints had been responded to. They told us records of emails would be saved on the system. We asked the assistant manager to access the records on the system which the registered manager referred to. However, they told us no complaint records were stored on the electronic system.
● People and relatives told us they felt the service was not always responsive to negative feedback or

complaints. Comments included, "I complained about the fact they don't ring if they are running late. I have only said if they are going to be late, please ring then I can get breakfast but that's never happened. It would be nice if they would just call. That's all I've ever asked for. They have never done as I've asked", "I have had issues all the way through with this company…I have complained so often about the times of the calls, nothing ever changes". Another person told us "I have complained. I am not particularly happy having younger girls."

The provider and registered manager failed to ensure effective systems were in place to identify, record and handle complaints. This was a continued breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The service did make referrals to external healthcare professionals when changes occurred in people's needs.
- The registered provider and manager had met with CQC and the local authorities on a regular basis since the publication of the last report.
- Since our site visit on 1 and 2 July 2021, communication with the service has been variable. We have not received all the requested information and the local authorities have told us the senior management team have not always attended planned meetings with them.