Pinnacle Brit Care Ltd

Pinnacle Brit

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pinnacle Brit provides personal care and support to older people and people with disabilities living in their own homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. At the time of our inspection all 24 people supported by the service received personal care.

People's experience of using this service and what we found
The risks associated with people's care were not always managed in a safe way. This included the provider not knowing whether staff had attended calls, poor management of medicines and risks associated with people's care not mitigated. People were not protected from the risk of neglect as staff were not always attending calls when required. Staff were frequently not staying for the full length of the call which was impacting on care.

An assessment of people's needs was not always undertaken when their health changed. People and relatives did not always feel staff were competent to deliver care. The supervisions staff received were not always effective in identifying and addressing shortfalls. Although we saw health care professional were consulted this was not always undertaken in a timely way. People were not always supported to have maximum choice and control of their lives.

People were not always treated in caring or respectful way although people and relatives fed back that some staff were kind and considerate. People's independence was impacted as staff were not always advising them when they were going to be late. People and their families did not always have input into their preferred call times which they fed back impacted on their lives.

Whilst we found improvements in the information in some people's care plans there remained a lack of personalisation and detailed guidance for staff specific to each person's needs. There was a lack of detailed information on people's preferences, their likes and dislikes and life histories. There was a lack of evidence in people's care notes that staff were providing the care detailed in people's daily care planners. There was a lack of robust investigation into the complaints or actions taken to make the necessary improvements.

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

Rating at last inspection and update
The last rating for this service was inadequate (published11 January 2022) and there were multiple breaches of regulation. We imposed conditions to the providers registration relating to the governance and oversight.

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

This service has been in Special Measures since 11 January 2022. During this inspection the provider demonstrated that improvements have not been made. The service remains rated as inadequate overall. This service remains in Special Measures.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. We have reported our concerns to the Local Authority safeguarding team. The provider has not taken action to mitigate risks to people.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not 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.

Pinnacle Brit

Detailed findings

Background to this inspection

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

Inspection team
Our inspection was completed by two inspectors and an Expert by Experience who undertook telephone interviews with people who used the service and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We called and spoke with four people who used the service about their experience of the care provided and spoke with seven relatives. At the office we spoke with three members of staff including the provider (who was also the registered manager), care supervisor and a member of office staff.

We reviewed a range of records including nine people's care plans, daily care notes, office dairy notes, staff rotas, multiple medication records, safeguarding records, training and complaints. We reviewed a variety of records relating to the management of the service including three staff recruitment files and spot checks. We called and spoke to a further four care staff and spoke with four health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment

At our last inspection we found there was lack of organisation by the provider to ensure staff stayed for the full length of time which we found impacted on people's lives. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had not improved, and the provider remained in breach of regulation 18.

- There remained a lack of organisation by the provider to ensure staff stayed for the full length of time at calls. Although the provider told us, and we saw from rotas, staff were given travel time in between calls, staff were still not staying for the full length of the call. Comments from people and relatives included, "They are supposed to stay for thirty minutes, but are usually in and out within 15 minutes, sometimes twenty." "We pay for a half an hour call, but they (the staff) are only ever here for ten minutes during the evening call." And, "I find that the carers do not stay the full length of time, they come and just do what they have to do."
- Staff were required to log into the services online system using a handheld device when they arrived at a call and when they left. The field supervisor told us, "In the week [member of office staff] will look at whether staff are staying for the full length of the call. It's not hard to look at. We don't have a lot of clients so it's not difficult." We reviewed the records of this and found staff were frequently not staying for the full length of their call, at times less than half the time required.
- We noted for 1 August 2022 for 39 care calls we reviewed there were 35 occasions staff had not stayed for the full length of the call. Eight of the call durations should have been for 45 minutes however staff were staying for less than half of this. There were no records to show staff at the office were addressing this with care staff.
- As on the previous inspection staff were not always arriving at calls at the agreed time which was impacting on people's care. For example, a relative told us, "The evening times are definitely not what we have agreed as the carers are arriving at 19.00hrs which is far too early for my husband to go to bed." Another told us, "We have asked for an earlier call time, but they have said they cannot do it, I have really just about had enough of it all, it is so frustrating." A third told us "The evening call is at 18.30hrs and it just means that my partner is in the same [continence aid] from then until they return as late as 10.00hrs the following day."
- The provider told us there were 12 people that required two staff to attend their calls as they needed to be supported to be moved. We noted there were no systems in place to assure the provider the second member of staff had turned up to the call. We found only one member of staff was logging into the online system for every call that required two staff. A member of staff told us of these calls, "We log in and log out. Only one (member of staff) does the log in." This meant there was a risk that people were being supported in an unsafe way.

● We saw feedback in July 2022 from one health care professional to the service that only one member of staff was attending a person's call instead of two. A relative told us, "About once a week only one carer will turn up on one of the calls because they are busy, my [family member] should have two carers."

Failure to deploy sufficient numbers of staff was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the provider had not operated effective and safe recruitment practices. 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 this had improved, and the provider was no longer in breach of regulation 19.

● Although no new staff had been recruited since the last inspection, the provider had reviewed all current staff files. We found appropriate checks had now been undertaken. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were also copies of other relevant documentation including full employment histories, professional and character references.

Systems and processes to safeguard people from the risk of abuse

At our last inspection of the service, we found the provider had not ensured people were protected from the risk of abuse and neglect. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 13.

● People were not protected from the risk of neglect. There were people using the service that would not be able alert the office if a carer had failed to attend the call. One person lived on their own and had a diagnosis of dementia. The provider told us a member of staff was never able to use the handheld device on this call to notify the office when they had arrived. On a recent call, a carer had turned up late by two hours and found the person had fallen. The provider failed to put safeguards in place, so they were alerted if a carer had not attended the call.
● Although the provider notified the local authority the person had fallen and an ambulance called, they failed to provide information to the local authority that the carer attended two hours later than planned. We also found no robust action had been taken to investigate how and why this had occurred. The provider told us the staff member wasn't at work however we saw from the rotas the member of staff had still been regularly attending calls..
● There were mixed responses from people and their families about how staff were with them. One relative told us, "I think that some are much gentler than others, as sometimes my wife will cry out when they wash her." Another said, "[Person] does get agitated and resistant to her care; the carers try to explain things to her, I have never heard them shout."
● One member of staff told us in relation to another person, "They (the provider) told me I should be calling them when I get there and call them when I'm leaving." However, there was no record that this was happening so the provider was not assured staff had attended the calls.
● One person fed back to the service that due to staff arriving late at calls they had missed breakfast as they were due at a health care appointment. This was despite the same concerns being raised to the provider by the person two months earlier. A relative fed back how staff rushing with calls had impacted on their family

member. They told us, "I had to tell them (staff) that they needed to take their time and to give him only small mouthfuls (of food). I felt that they were rushing him and when they left my husband was panicky."
● Staff received safeguarding training and were able to describe types of abuse. However there remained a lack of understanding of who they report concerns to outside of contacting the office. One told us, "I can google CQC and do it anonymous." Another told us, "I would call them (office) again to remind them because I don't want to take law into my own hands." The member of staff said if they felt staff in the office were not responding they would contact the Police. Staff were not provided with contact details of the safeguarding team at the Local Authority and were not all familiar they were the lead agency for safeguarding concerns.

As people were not always protected from the risk of neglect this is a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last two inspections of the service, we found the provider had not ensured the risks associated with people's care was being managed in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

● Whilst there had been some improvements in care plans around the assessment of risk, this was not consistent. We identified multiple instances where risks had not been assessed or actions taken to mitigate these risks. For example, where people were at risk of falls there was not always risk assessments in place. One care plan stated a person walked with a frame and had spent a lot of time in their recliner chair. There was no information on whether the person could get up from the chair independently or any risk assessment in relation to this.
● Another person had recently come out of hospital, their mobility had decreased and now required a frame to walk with. The care supervisor told me the person's care plan in the home had been updated to reflect this. However, when we checked their care plan it still stated the person only required a walking stick. The care supervisor told us they believed they had updated the risk information and said, "I read it and proofread it and I didn't see it was wrong." They also told us the person had become, "Increasingly confused." However, there was no reference to this in the care plan. This meant there was a risk staff were not providing the appropriate support.
● Another person was at risk of choking and their care plan stated they required a soft diet. However, their summary care plan made no reference to the person requiring soft food and referred to staff ensuring the person is left a cup of tea and biscuits. There was a risk staff would give the person foods that were not suitable. The person's risk assessments and care plans have been updated since the inspection.
● One person had raised a complaint to the service they were concerned that staff were not always positioning their pressure stocking correctly (to reduce the risk of blood clots). They stated this caused them to have swollen ankles. There was no mention in the care plan that they needed pressure stockings or the risk to them if not fitted correctly. This was despite the providers medicine policy stating staff should check medicine administration record (MAR) for specific instructions related to the type of stocking used. The provider has sent evidence since the inspection of this now being included in the person's care plan.
● One person's care plan stated they required two staff at all time to assist with moving and handling. It stated the person required a hoist for all transfers. However, there was no risk assessment in relation to this or guidance for staff on how use the hoist in a safe way to reduce the risk of injury to the person. The provider has told us this has been addressed since the inspection and have updated the care plan.
● We saw from daily notes in July 2022 that staff were recording concerns about a person's skin integrity and

they had reported this to the office staff. We saw a health care professional had been contacted about the person needing a pressure cushion when sat in the chair. Despite this, the person's care plan had not been updated to reflect this concern and no skin integrity risk assessment had been completed.
● Although staff were now recording some incidents there was little evidence of learning from these incidents. For example, in March 2022 one relative had raised concerns about staff turning up late for calls which was impacting on their family member's care. The provider had not taken appropriate steps to make improvements and incidents of this were still occurring in July 2022.
● Incidents of behaviour were not always being recorded and analysed to look for themes and trends. According to a person's daily notes there had been incidents of anxious behaviours towards staff. There was little detail around the incident or what actions staff took to support the person. These incidents were also not recorded on forms despite the care plan stating, "Call the office to report concerns and complete an incident form, give full details in care logs." There was no behaviour plan to consider strategies when the person became anxious.

The failure to not always manage risks associated with people's care in a safe way is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were some aspects around the assessment of risks that were undertaken in a safe way. One person required a catheter and there was information in their care plan for staff to ensure the catheter was working effectively and to report concerns.
● Another person had epilepsy and there was a risk assessment and guidance for staff on what they needed to do should the person have a seizure. This included a description of the seizure and when they needed to call an ambulance.

Using medicines safely

At our last inspection of the service, we found the provider was not managing medicines for people in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

● At the previous inspection we found people's medicines administration records (MAR) were not always in place where staff were administering medicines. At this inspection we found there were MARs in place however there was not sufficient information to guide staff in the safe administration of medicine.
● The management of medicine was not undertaken in a safe way which put people at risk. The field supervisor told us, and we saw, there was a record in people's care plans detailing what medicines people were receiving, people's allergies and possible side effects. However not all of this information was recorded on the MAR. This meant, staff would have to look through people's care plans to find this information.
● All of the prescriptions had been handwritten on the MAR which were not completed by appropriately trained and competent members of staff to ensure their accuracy as per NICE guidance. The field supervisor was completing the MAR and assessing the medicine competency of all staff. However, there was no evidence on the training record the field supervisor had been assessed as competent. The MAR failed to include information on whether the medicine should in tablet or liquid form.
● Where people had been administered 'as required' (PRN) medicine such as pain relief, staff were not always recording why the person required this. One person's MAR stated the person had been given PRN paracetamol in the morning however staff had not recorded what time this was given. This meant the member of staff on the lunch call would not know when it was safe to give the next dose of paracetamol.

● There was no information in one person's care plan on the importance of staff arriving on time to administer their time critical medicine. We saw on one person's MAR they required time critical medicine three times a day, at the same time with four hourly intervals. A member of staff we spoke with knew the importance of giving the medicine on time and said they should, "Never miss a medication time." However, we saw from their daily records there were longer gaps between the medicine being administered. There was a risk this would have a detrimental effect on the person's health.
● After the inspection the provider told us they would monitor the calls to ensure staff attended the call to provide the medicines at the appropriate time.

The failure to not manage medicine administration in a safe way is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● People told us staff wore personal protective equipment (PPE) when they delivered personal care to reduce the risk of spreading infections. One told us, "The carers always wear masks, gloves and aprons"
● When we arrived at the service the provider and staff wore masks and requested us to provide evidence of a negative lateral flow test.
● Staff were provided with sufficient PPE and were aware of what they needed to do to ensure the prevention of infections.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

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

- People were not always assured staff were competent with their support. There was mixed feedback from people and relatives around the competencies of staff. Positive comments included, "The carers do use the hoist properly, and they talk to my husband explaining what they are doing while using it" and "The carers know what they are doing." Whilst other comments included, "Sometimes carers come who do not have the right experience and start to use the hoist, but I have to stop them to show them how to use it properly" and "Sometimes I have noticed that the carers do not know how to sit my husband on the commode chair and his bottom is right on the edge."
- At the previous inspection we found staff had not received specific training in relation to the needs of people they were supporting. We identified the same concerns on this inspection. It was identified that two people had specific health needs. According to the training records staff had not had any training around these needs. This meant staff may not provide the most appropriate care in relation to the specific conditions.
- On review of the training records, not all staff providing care were listed as having received any training at the service. A person raised complaints about a member of staff's competence at their care call. There was no record relating to any training or supervision with this member of staff.
- Staff we spoke with fed back they received training however this was not always effective when delivering care. We found shortfalls around the management of risk, safeguarding processes and the safe management of medicines.
- The provider failed to ensure care staff had received appropriate support that promoted their professional development and assessed their competencies. This was a concern identified at the previous inspection. Although we saw copies of supervisions and spot checks these were not effective in addressing shortfalls in practice.

As there is lack of staff training, knowledge and competency this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection of the service, we found the provider was not ensuring an appropriate assessment of people's needs was undertaken before they accepted the package of care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 9.

● Since the last inspection the provider had not taken on any new clients. However, we identified concerns in relation to the assessment of people's needs where they were returning to home after a period in hospital. One person had spent four weeks in hospital. The care coordinator told us they visited the person in hospital to assess their changing needs. However, they told us they did not know the reasons they were in hospital. They told us, "Not really clear why they kept her in apart from maybe concerns with mobility." This meant there may be important information missing from their care plan in relation to the person's health. We confirmed with a health care professional the person was not visited in the hospital by staff to review their care. A member of staff told us, "What they (the provider) need to improve on, make sure they do their assessments before they send people home ."
● We saw from the office diary, another person was admitted to hospital due to a concern raised by staff. Although they returned to their home that day, there had been no review of their health needs by the provider to determine whether any additional care needed to be provided.
● The reviews of people's care were not effective in ensuring the care provided was appropriate. We noted in a care plan a person had raised concerns about the quality of care. However, we saw a quality check by the care supervisor had taken place at the same time where it was recorded, "No changes to health or care in general."
● Staff were not always responding to people's health concerns in a timely way. We noted from the care notes of one person, staff had recorded a deterioration in the person's health over a period of four days. It was only on the fourth day; it was recorded the person asked the member of staff to call the GP. There was no record made of the outcome of the call to the GP.

As an appropriate assessment of people's needs was not taking place, staff were not always sharing concerns about people's care and appropriate health care professionals were not always quickly consulted in relation to people's care this is a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some care plans that had information for staff on how to assist people with their oral care. This included whether the person was able to do this independently or how the person preferred to be supported.
● There were staff that responded in a timely way when they had health care concerns with people. One relative told us, "One time the manager called to say that the carers were worried about my husband and asked if they could ring the GP about him, I said that was okay and the GP called that afternoon." Another told us, "My husband can get urinary tract infections and if I ask the carers will obtain a urine sample for me and drop it off at the GPs. The carers will also let me know if my husband's skin is getting marked."
● We saw in the office diary where the office staff and the provider had contacted health care professional when they had concerns.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection of the service, we found the provider had not ensured the requirement of MCA and consent to care and treatment was followed. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 11.

● The provider lacked an understanding of the principles of MCA which meant there was a risk that consent was not gained from people appropriately. One person's care plan stated they lacked capacity and an assessment had been taken around this in relation to providing care. The best interest decision stated, "My daughter helps make decisions in my best interests about assistance from professionals" however it then stated the person does not have a next of kin or person who can help with decision making. This meant there was a risk that decisions may be made for the person without following the principles of MCA.
● Another person's capacity had been assessment around care and deemed to lack capacity. The care plan stated the family had Power of Attorney (POA) however the provider had not requested evidence of this. The care supervisor told us they had requested to see this, but it had not been provided. They were also unable to tell us whether the POA was for health and welfare and/or finances. This meant decisions may be made for the person by the representatives without them having authority to do so.
● In all of the care plans we looked at there were capacity assessments regardless of whether the person's capacity was in doubt. One of the five principles of the MCA is, 'A person must be assumed to have capacity unless it is established that they lack capacity.' The provider was not applying this to people they were supporting.

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

● Staff told us they received training and had an understanding of MCA. One told us, "The mental capacity is part of the training I have had. If the client has the capacity to decide on their own. If they have dementia it doesn't mean they cannot consent, we cannot judge them."

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

● There were care plans providing information for staff on whether people required their meals to be prepared. We saw from daily notes that where required staff were providing these and ensuring people had a drink available.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion, staff caring attitudes had significant shortfalls and there were breaches of dignity.

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

- At the previous inspection we found people did not benefit from full support from staff as they were not staying for the full length of the call. We found the same concerns on this inspection. People and relative told us this impacted on the choices around care. One relative told us, "My [family member] used to like a shower but does not have one anymore because the carers rush him." Another told us, "My [family member] wears a [continence aid] but the carers never ask him if he wants to go to the toilet."
- People did not feel that staff were always caring and considerate. One relative said, "The carers are really not the happiest of people… [staff member] does not talk to my [family member] when he is giving his care". Another relative said, "They do not talk to me and my wife." A third said, "Sometimes they do [family members] care without speaking to her."
- People and their families independence was impacted as staff were not always advising them when they were going to be late. One person had fed back to the service how this impacted on them and said, "They (staff) are effectively controlling on which days I can plan to go out and at what times." A relative told us, "There was another occasion when the person did not turn up, despite me booking them. I had planned to meet a friend and had to cancel."
- People were not always treated in a dignified and respectful way. One person told us, "The carers do not encourage me; they do not protect my privacy by covering me up when they are washing me." A relative told us, "I do wish they would cover him when they are drying his back." One relative said, "The carers do not respect our home, they bang things around and do not seem to care."
- A relative told us, "One of the carers will stand next to my [family member] saying 'Jesus, Oh Jesus' (when providing personal care), I mean you should have patience when doing a job like this."
- People and their families told us they were not always told when carers were going to be late. Comments included, "If they are running late however no one rings to let me know" and "Sometimes I have to ring to check they are coming in the evening as they can be late arriving."

As people were not always treated with dignity and respect this a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people told us they received care from staff who were kind and caring. Comments from people and relatives included, "The carers are kind and caring, they know what I want, and they have fulfilled that for me", "The carers stay calm with my husband and reassure him, one carer in particular is excellent and they get on very well" and "I do find the carers friendly and respectful."

● There were some people who did feel their independence had been supported by staff. One person told us, "The carers have helped me to become more independent as I was in bed when I first came out of hospital, but I can now get myself up." A relative told us, "We find the visiting carers good too, they are all working on [family member] and encouraging her to transfer using a board onto a wheelchair."

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

● People and their families did not always have input into their preferred call times. One person told us, "I would say the carers are quite good, but the times they arrive do vary. I just have to wait for them to arrive." One relative told us, "We have asked for a later call; but they have told us that it is not possible, so this week we have tried to manage a couple of times without the evening call." Another told us, "It is very difficult for them to give me set times, so I never know what time they are coming and how long each carer will be here."

● People were not always asked about their preferences around their care. There were no records in care plans around whether people would prefer a male or female carer. The provider told us they asked this at the start of the package and if this could not be provided, they would let people know. However, there was no record this was asked of people or any other preferences.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

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

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

- Whilst we found improvements in the information in some people's care plans there remained a lack of personalisation and detailed guidance for staff specific to each person's needs. One person told us, "The folder in the house from the company is a mockery, it serves no purpose whatsoever."
- One person had diabetes and there was no specific care plan for this. Another person had a particular health condition but there was no care plan in place advising staff what the condition was and how the person was affected by this.
- A provider information return (PIR) is information the provider shares with us prior to the inspection, they said 'Pinnacle Brit ensures individual's care plan truly reflects their physical, mental, emotional and social needs.' The provider told us one person's emotional needs had increased and would express their anxiety towards staff. There was no care plan around this or strategies for staff on how best to manage the person's anxieties.
- There remained a lack of detailed information on people's preferences, their likes and dislikes and life histories. This increased the chance that staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life. One relative fed back, "The assessment is in the folder that we have; it is very brief with a choice of answers of either yes or no. I cannot remember being involved in the assessment."
- There was a lack of evidence in people's care notes that staff were providing the care detailed in people's 'task planners.' One person's task planner stated staff were to check the person's continence aids on each of the four calls they had each day. Other than the morning calls there was no references in the daily notes to this being done.

● One member of staff told us they predominantly provided care on the weekend as an agency carer. They told us of a person, "Every Sunday I shave him as he requested that personally." There was no reference to this on the person's task planner which meant if another member of staff covered the weekend call, they may not know to provide this care.
● Another person's task planner stated staff were required to stay with the person whilst they ate their lunch. There was no mention in the person's notes this was being done.
● Since the last inspection there were some improvements in the records of how staff best communicated with people. However, this still required improvement as in one care plan it stated the person had communication difficulties There was no information on why this was or guidance for staff on how staff best to support them with communicating their needs.
● Another person's care plan stated they had a good level of hearing. A local authority assessment stated the same person was 'hard of hearing'. Their care plan stated they had a low level of communication due to their diagnosis of dementia. However, the person's first language was not English, and this was not clear it had been considered in relation to their communication barriers. This was despite the PIR stating, 'Pinnacle Brit would ensure care staffs are aware of the individual's needs and would provide appropriate support to meet the individual's identified communication needs.'

Care and treatment was not provided in a way that met people's individual and most current needs. This is a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

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

● Since the last inspection there were records being kept centrally of some of the complaints received by the service. However there remained a lack of robust investigation into the complaints or actions taken to make the necessary improvements. One relative told us, "I have rung them and told them how frustrated I am with the call times, they tell me that they will see to it, but things are just left as they are." Another told us, "I have raised that it is an issue that they do not tell us when the carers are going to be late, and it is a problem that things change and then it just goes back to how it was."
● One person had submitted a complaint in March 2022 about the quality of care. We could see that a spot check was undertaken to the person's home as a result. However, the person's submitted a further complaint in June 2022 around the same concerns and felt the care had deteriorated. There was no evidence of any formal response to the concerns other than a further spot check taking place and an email to the person in July 2022 to see how their care was. There was no evidence this was followed up.
● Another person had submitted a complaint in June 2022 relating to infection control. A note on the complaint stated the member of staff was to complete infection control training. However according to the training record this had not taken place.
● A relative had submitted complaints in relation to staff not staying for the full length of the family member's call. We found these concerns were continuing and appropriate actions had not been taken by the provider to address this.
● A note had been recorded in the office diary for July 2022 that a district nurse had raised a concern about a person they had seen that day. The concerns related to two carers not always attending the call as required and staff rushing the person with care. This was not recorded in the complaints folder and there

was no evidence of an investigation into this other than the provider asking staff to ensure two staff attended.

● The PIR stated, 'Pinnacle Brit is willing to listen and learn from complaints and concerns raised. By learning from each complaint and finding ways to both prevent future complaints and address current complaints, we aid continuous improvements within our service.' We found this was not the case and there was a lack of continuous learning and improvements.

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

End of life care and support

● Since the last inspection we found end of life care plans had been placed in people's care plans. This included who to contact and to remain at home. The provider told us they were not currently supporting people with end of life care.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

At our last two inspections of the service, we found the provider had not ensured there was ongoing and robust management oversight to ensure changes and standards were maintained. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

● The provider failed to ensure there were effective, systems in place to monitor the delivery of care this impacted on the care people received. Since the last inspection the provider had been required to send us monthly reports of the oversight of care. We found evidence on this inspection that did not accurately reflect what we were being told on the reports.
● At the last inspection we identified staff were not staying for the full length of the call. We continued to find this despite the provider telling on this inspection this was no longer a concern and that they had better oversight of this.
● The provider had failed to ensure there were robust systems in place to alert the office where staff either arrived late for a call or failed to attend a call The provider told us the electronic logging in system would alert them if a member of staff had failed to log into a call 15 minutes after the call was due. If staff were unable to use the electronic system staff were required to either text the office or call in to confirm they had arrived. We found numerous incidents where staff had arrived more than 15 minutes late for calls with no records of the office staff contacting the member of staff to establish if there was a concern.
● The provider told us they were "fairly confident" staff stayed the full time unless they have been asked to leave by the person. They told us the field supervisor would call the member of staff why they failed to stay for the full length however the field supervisor told us they did not record all of these conversations.
● The provider was not always open and transparent with us during the inspection. We were made aware of an incident where a member of staff had arrived two hours late for a call in July 2022 and the person had fallen prior to the call. The provider told us they were investigating this, and that the member of staff was not working. However, we saw from rotas the member of staff was still attending calls.
● The provider told us there had only been one missed call since the last inspection. On review of one person's care plan we saw at least one other incident of a missed call which had not been investigated by

the provider.
● The provider was not open and honest with people and their families when something went wrong with their care. We identified incidents of missed calls, late calls, staff not staying for the full length of the call where complaints had been made. It is a legal obligation that care providers must inform the people affected by the incident, offer reasonable support, provide truthful information and a timely apology. We found this was not happening.
● There was mixed feedback from people and relatives about the management of the service. Positive comments included, "They are a well-managed service; they do their job", "The company is well managed I cannot fault them as they have done everything that I have needed". Whilst other comments included, "I really do not think that the service is well managed, they really are not very good as I find myself repeating things to them all of the time", "The service does not communicate very well at all; I never hear from them" and "I have contacted the office to tell them not to send a carer on a particular day and then the carer turns up as the office has not told her."
The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

At our last two inspections of the service, we found the provider had not established effective systems to gain and act on feedback. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

● The provider failed to have effective systems in place to gain feedback from people and their families about the quality of care. We saw the care supervisor completed forms with people however where concerns were fed back there was a lack of action taken on the feedback.
● A person had recently provided comprehensive feedback to the provider about the quality and safety of care. However, when we spoke to the provider about this, they told us, "This is all down to preference and the staff [person] will accept." This demonstrated the provider was not taking steps to make improvements following feedback.
● People and relatives told us they were not asked to provide any formal feedback. Comments included, "We have been using the company for a year and have not been asked our opinion about it, we have not received a survey" and "I have not received a survey, I do contact them about timing issues, but there is never any improvement."
● Although the provider had undertaken a survey with people at the end of 2021 there was no robust actions taken as a result of the feedback. The survey action plan stated, 'Action Plan for next year will be ECM [call monitoring], effective rostering, continuous auditing of communication log emphasising more on detailed and eligibility of writing documents and following care task adequately.' We found there had not been sufficient improvements in these areas.
● People and their families fed back they were frequently not consulted when staff were going to be late. One relative told us, "I wish they would keep me informed if the carers are going to be delayed, they help my [family member] with her cleanliness, and it is important that they arrive at regular times." Another said, "The biggest issue for me is that if they are late, I have to contact them to ask what is happening."
● Staff were not given an opportunity to feedback where improvements could be made to the service. Staff

told us they were not asked to write surveys which they said they would appreciate. One member of staff told us, "They never give me a survey. That would be great, that would be helpful, so they know what they are doing well." Another said, "I don't think I have received a survey; I thinks it important to improve the service. It would be mean we are free to say what we want."

● Although staff meetings were taking place there remained no system of asking staff for feedback. The minutes of staff meetings included reminding staff about uniforms, communication, professional conduct and training. However, there was no notes of staff being asked for any feedback where they felt improvements could be made. This was a concern raised at the last inspection.

● Staff were on whole complimentary of the management of the service and comments included, "It's fantastic, they are really so supportive", "It has greatly improved. I can communicate with [office staff member] who is very responsive" and "I do feel supported, we get a nice gift in December. They cover your shifts for you." Despite this staff also said that some communication could be improved upon. One member of staff told us, "I have mentioned, communication could be improved, its important, there may be a change of medication, the carer in the week should let me know, but sometimes there is a delay."

● Internal processes to audit or review service performance and the safety and quality of care were not operating effectively. Audits taking place were not identifying or preventing issues occurring or continuing at the service.

● People's MAR's were collected from their home each month and audited by a member of office staff. We found these were not identifying the shortfalls we found. For example, on one person's MAR for June 2022 there was no information on allergies or GP details. There were frequent incidents where the person was refusing their medicines with no record made by the member of staff why this was. The audit did not identify any of this and was signed off as no issues identified.

● Audits of people's handwritten daily notes were not effective in ensuring all of the care information was present or addressing concerns. In one person's daily notes for May 2022, it was frequently recorded the person was, "not ready" for lunch when carer arrived at 12.00. There was nothing on the audit to question whether12.00 was an appropriate time for the lunch call. We saw in another person's daily notes on four separate occasions in July 2022 the person was referred to by three other client's names. This had not been identified on audits of the notes by the provider.

● The May 2022 written notes for a person were at times hard to read and were not reflecting the task planner for the person. There was reference in the audit the notes could be more detailed, however, there was no evidence of any actions taken and no change shown in the June 2022 notes. The June 2022 audit of the notes stated there were no concerns.

● We were told by the provider a member of office staff was responsible for reviewing the accuracy and quality of people's care plans and staff spot checks. We spoke to this member of staff who told us this was not a role they had been allocated. There was no evidence of any audits on people's care plans.

● Where we identified there were frequent incidents of staff not staying for the full length of the call. There was no evidence the provider had consulted the funding authorities in relation to this to query whether the length of call was required. We fed this back to the local authority.

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