PLL Business Solutions Limited

PLL Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
PLL Care Services is a domiciliary care agency that provides personal care to people in their own homes.

The service provides care to older people, people with a learning disability and/or autistic people, people living with mental health needs, dementia and physical disabilities.

Not everyone who used the service received personal care. Care Quality Commission (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 our inspection the service was providing care to 169 people.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found

Right Support
Robust safeguarding procedures were not embedded into practice. Concerns had not always been reported to the local authority as required and systems were not reviewed to minimise the risk of them happening again. Care plans and risk assessments did not always contain relevant, up to date information within them or were not available. Risks to people's safety were not always identified or mitigated. Therefore, staff did not always have the information required to provide safe and effective care and in relation to people's specific health conditions.

People did not always receive their medicines safely and referrals to health care professionals were not made in a timely manner.

People were not supported to safely manage their medicines and did not always have access to their medicines. Topical medicines such as creams were not always documented adequately to ensure staff knew about these creams or where to apply them, and missed medicines were not always followed up by the provider.

People were not always supported by staff who had been safely recruited. Recruitment information contained contradictory start dates. The provider completed police checks but could not always evidence they had gained references for staff prior to them starting work.

Documents indicated that staff received an induction before working with people. However, we received mixed reviews from staff about their training.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: Care was not person-centred and did not promote people's dignity, privacy and human rights. Care plans were not person-centred and did not always contain information which would support staff to know the person they were supporting. Spot checks evidenced that people were not always treated with dignity. People and relatives were not always involved in reviewing of care needs.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives.

Effective quality assurance measures were not embedded to ensure a culture of continuous improvement. Audits and spot checks of staff competence had not been completed routinely and accidents and incidents were not reviewed to minimise the risk of them happening again. The provider did not share information in an accurate or transparent manner. Numerous discrepancies were found between information given by the provider and details obtained from records, staff and other professionals. Discrepancies included basic details such as the number of people supported, how people's care was funded and how many staff were employed. The provider had not notified CQC of safeguarding concerns as required by their registration. Feedback from people regarding the quality of the care they received was not regularly sought. Staff meetings were not used as a forum to share ideas and learning but as a way for the provider to share instructions. Staff did not receive regular supervisions to support them in their roles.

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

Why we inspected
The inspection was prompted in part due to concerns received about safety of the service. These concerns were around up to date and accurate records and assessments not being in place. There were also concerns about the effectiveness of the management in relation to governance by ensuring the service was safe and of a high quality. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

We asked the provider to provide an action plan following serious concerns found during the inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to person centred care, safe care and treatment, good governance, staffing and fit and proper persons employed at this inspection.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

PLL Care Services

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
The inspection was carried out by 2 inspectors, 1 medicines inspector, 2 offsite inspectors who carried out staff calls and supported in reviewing care plans. We also sought peoples and relatives' views by telephone from 2 Experts by Experience. 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 15 August and ended on 6 September 2023. We visited the location's office on 15 and 16 August 2023, and met remotely on the 6 September 2023 to provide further feedback.

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
During the inspection, we spoke with the registered manager and the nominated individual.
The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to 12 care staff, 3 care co-ordinators, 5 people using the service, and 12 relatives of those using the service. We looked at records including 10 care plans, assessments, medicine administration record charts (MAR), 6 staff files, including information about recruitment. We also looked at a range of records relating to the safety, quality, and management of the service.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people safety and well-being were not consistently identified and addressed. We found multiple instances where risks had not been assessed, mitigated or guidance had not been provided to staff to manage the risks.
- Risk management plans had not been consistently developed for specific healthcare conditions such as diabetes, catheter care and epilepsy. There was a lack of guidance available for staff around risks associated with specific health conditions, the support required and how health conditions impacted the individuals concerned. This presented a risk as people may not receive the care and treatment they required to minimise the risk of harm.
- Assessments were not reviewed regularly to ensure they included up to date information around the risks to people. This was the case for 10 care records we reviewed. For example, 1 person's care plan detailed they were unable to get to the toilet and used incontinence pads during the day and night requiring double handed support to transfer. Risk assessments in place incorrectly stated the person's skin was intact, they mobilised independently and were continent. In addition, there were no risk assessments in place for continence or skin integrity and care notes documented carers were 1.5 hours late to morning care calls. This put this person at risk of damage to their skin.
- A person had a diagnosis of epilepsy. Although this was noted in their care plan, there was no risk assessment regarding the types of seizures this person had, and what staff should do if this occurred. Staff we spoke with were not sure what action they would take if this person had a seizure. This put people at risk as staff did not have the information required to support them safely.
- People did not have specific risk assessments or guidance in place where required. For example, 1 person had a (pressure adaptable) mattress on their bed. The care plan stated to 'pump up when required.' There was no risk assessment in place for this person's skin integrity and no further guidance about the appropriate mattress setting. Risk assessments in place indicated this person's skin was intact despite having pressure damage and equipment in place.
- A person's care notes documented they were at risk of harm to and from their partner and staff supporting them. There was no information for staff about this risk and what action they should take to reduce the risks of harm.
- Relatives of those using the service told us "We don't really have any concerns although [person] uses a (transfer aid). Sometimes they [staff] have to pull [person] up which they shouldn't really be doing, they need to encourage [person] more to help." We also heard "I think they [staff] do their job, could be a bit lax with moving the catheter - a bit careless."
- Risk assessments in place often contained incorrect information, such as other people's names or incomplete sentences. After the inspection, the provider told us they had checked all care plans and rectified these where required.

● Staff did not always follow-up on concerns raised by their colleagues at previous calls. One person's records stated they had a large open wound. Care notes stated the wound was very sore and open, at the next visit another member of care staff documented it was healing. This did not always allow for an accurate record of the persons safety and put service users at risk of harm.

The failure to ensure people received a safe service was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe Care and Treatment.

Using medicines safely

● Systems were not in place to ensure people's prescribed medicines were available to them. The provider was unable to assure themselves people were supported to take their medicines as prescribed. Five people's records showed they missed medicines. Medicines were not available, and often there was no explanation documented as to why people did not receive their prescribed medicines.

● People's medication administration records (MAR) were not always accurately followed. A person's MAR gave instructions for 1 medicine as 'Take 1 or 2 tablets 3 times a day, for pain relief.' Within the MAR chart 2 administrative times were listed on the MAR not 3. This would not allow for staff to provide the service user with pain relief a 3rd time if they required this.

● There was limited or no direction to correctly administer and record prescribed creams. A person's care plan gave no direction of where to apply creams, there was no body map used and we saw that a cream not on their medicines record was being used by staff. There was no direction of where or how often to apply this cream. Another person's cream was not administered on 5 occasions and recorded as not required but no detail as to why this was. This cream was not a PRN (as required) medicine so should have been applied regularly. Another person's care plan detailed staff to apply creams, however the person had no creams listed on their MAR and their care plan stated the person had no problems with their skin. This meant people were at risk of not receiving prescribed creams and placed people at risk of experiencing skin damage due to incorrect care.

● A person was given a medicine they were no longer prescribed. Communication logs evidenced this medicine was removed from the person's MAR chart following advice from medical professionals.

● Medication risk assessments for 1 person contained information stating family members collected their medicines from the pharmacy. However, this person did not have any family involved in their care. The pharmacy attempted to deliver their medicines. However, as this person was unable to access the front door due to their mobility, they missed these medicines for 3 weeks. This put this person at risk of damage to their skin due to incorrect information and poor communication.

● Staff were not assessed to ensure they carried out medicine administration correctly and safely. During spot checks on 2 occasions staff administered medicines to people on a spoon. The spot check spreadsheet documented that 1 member of staff had been referred to medication refresher training, however the other had not. The refresher training log did not evidence that this member of staff received this refresher training following the spot check. Training records indicated staff had received training in medicines however, there was no formal documentation recorded for competencies which would assess and demonstrate staff's ability to administer medicines safety.

● There was no medicine audit in place, therefore the service had not identified issues with people's medicines found on inspection. This continued to put people at risk of harm from not receiving their medicines as prescribed.

● Staff we spoke demonstrated an awareness about medicines however, confirmed they did not have medicine competencies. 1 member of staff told us "Pain relief should be given every 4 hours, we try to come every 4 hours, but sometimes its 3.5 hours."

The failure to ensure robust medicines management systems were in place was a breach of Regulation 12 of

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

Systems and processes to safeguard people from the risk of abuse

● Safeguarding concerns were not consistently reported to the local authority or recorded. Prior to the inspection the local authority made us aware of a number of safeguarding concerns raised by the council or supporting professionals that the service had been made aware of. Not all these concerns had been recorded and investigated by the provider in line with their responsibilities.

● Systems were not used effectively to safeguard people. There were times in which safeguarding referrals and other incidents had not been submitted by the service and where CQC and other relevant bodies such as the local safeguarding board had not been notified. This meant there was limited assurance incidents were being investigated and acted upon appropriately by the provider.

● For 1 person using the service, their communication documentation stated safeguarding referrals had been made, however, there was no oversight any action documented, therefore it could not be monitored.

● There was no system in place to record and action safeguarding concerns as there was no safeguarding log in place. We received a log which contained the safeguarding reference number however, it did not contain any further information about who the referral was for or what action had been taken to safeguard service users.

● One person experienced neglect on 2 occasions. During a care visit no fluid or medication was given, and no fluid was taken since the last visit. There was no explanation about this within the notes. Another entry detailed 'Found [person] well gave [person] a wash and left [person] in bed with the husband.' During this call, no medicines, breakfast, or personal care was delivered as the staff member had documented the husband manages this. This person did not have a husband. This inaccurate information had not been identified by the service, which put people at risk of neglect.

● Staff were unable to demonstrate understanding of safeguarding processes. Although staff had completed safeguarding training, they were not all able to describe how they would report these concerns. Staff did not feel able to raise concerns with management. We heard, "From the time I joined, I'm told not to say anything, I can't tell anyone if it was about staff or admin. If the concern was from a client I could say, but then all staff would know." After the inspection the registered manager told us they had implemented a number of initiatives to promote a culture where staff feel they can raise concerns.

The service had failed to implement effective systems to identify, investigate and appropriately respond to allegations of abuse. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● Recruitment procedures were not operated effectively to ensure persons employed met the conditions in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This states that certain information must be obtained in respect of people employed.

● There was limited evidence to demonstrate the persons employed for the purposes of carrying on a regulated activity were of good character, have the qualifications, competence, skills and experience which were necessary for the work to be performed by them.

● Required recruitment checks on staff were not always made. Documentation showed gaps in staff employment history with no explanation or was left blank. Not all staff had references. Staff members start dates were documented as being before the service received their application and, in some cases, start dates were before the interview date. We also saw confidentiality agreements were signed before their application received, and for 1 staff member their induction was recorded as being before their application was received.

● Dates did not always correspond across recruitment documentation. We received 2 members of staff

interview records after the inspection. They did not correspond to the dates within their folders. Training was seen for 1 staff member in January 2023 before applying for a job in April 2023. Five members of staff start dates did not match the training matrix start dates.

● Medical questionnaires were completed for some staff. However, these were not always appropriate. Questions included 'are you able to carry out strenuous physical work including climbing ladders, working from scaffolding, bending, lifting and carrying'. This was not relevant to the job description.

● Relatives of those using the service told us, "There are a lot of them [Staff]. We never get the same staff. There is a team of about 8 people - A lot have disappeared" and "Yes [person] feels safe on the whole with carers although [person] does say that they send a lot of new people which [person] can find confusing at times."

Recruitment procedures were not always operated effectively to ensure staff employed were of good character or suitable for the role. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Fit and proper persons employed.

Learning lessons when things go wrong

● Lessons learned were not always evidenced as being communicated effectively. Four staff meetings had taken place. Meetings did not demonstrate lessons learnt or individual risk.

● The provider did not have systems in place for learning lessons when things went wrong. Seven accidents and incidents were recorded but were not reviewed or analysed for patterns or trends.

● There were additional incidents we became aware of which were not documented within incident and accident records, such as a person suffering a fall which resulted in bruising of the face with no action taken at the time of the fall, missed medicines, and incidents of abuse towards staff. Systems did not take account of all incidents and the service did not sufficiently monitor accidents and incidents.

● We heard from staff that information around incidents was shared via use of the messaging service WhatsApp. We heard this service was used to share updates on people, as well as to report incidents and documented complaints made about staff. We heard people's names, and postcodes were used to identify people.

The provider failed to support the confidentiality of people using the service. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Good Governance.

Preventing and controlling infection

● Staff used personal protective equipment (PPE) effectively and safely.

● Staff told us they had access to PPE when required and this was supplied by the provider.

● People using the service and their relatives told us "They [staff] all wear ID badges and PPE when necessary. They also provide meals for my parents and that is always fine and hands are washed first."

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider failed to ensure people's needs had been assessed, monitored and managed in line with best practice guidance. Care plans and risk assessments did not contain updated, factual information or evidence assessments had been completed to ensure staff had the skills and knowledge to support them.
- Recognised best practice tools were not used to assess risks and monitor people's wellbeing. These included assessment tools used to assess people's skin integrity, nutritional needs and the risk of falls. This put people at risk of their needs in these areas not being identified and preventative action was not taken.
- The provider failed to have systems in place to implement best practice for oral health care. A person's care plan documented they wore dentures which needed to be cleaned as well as their teeth. There were no detailed oral health assessments to guide staff with information such as, the type of brush or tooth paste to use and what was used to clean the dentures. Care notes contained no information about oral care and therefore put the service user at risk of not receiving personalised support from care staff.
- The lack of robust assessments meant the service was not always providing people with the care they needed and wanted.

The service did not ensure that care plans fully identified or met people's needs. This was a breach of regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Person centred care.

Staff support: induction, training, skills and experience

- The provider failed to ensure suitably trained and supervised staff were deployed to meet people's needs. Not all staff felt they had the skills to support people, and access to further training if required and not all staff had received appropriate training.
- The training matrix did not contain information for all staff working for the company. Staff were missing from the matrix. Training certificate dates did not match the information within the matrix and was not updated to reflect refresher training provided. Due to inconsistencies within the training matrix dates and staffing, we were not assured all staff had received appropriate training.
- During the inspection we received evidence that 3 members of staff had completed Percutaneous endoscopic gastrostomy (PEG) training. Following the inspection we received evidence for 8 other staff. We did not receive evidence that all staff working with service users who required PEG support had received adequate training. We saw that some staff had undergone refresher training on stocking support, however this was not documented within the training matrix. The matrix contained a training called 'mental health, dementia and learning disability essentials'. Not all staff working with people who had a learning disability

had completed this training. There was limited evidence available to demonstrate that all staff were trained adequately to provide support to service users. This put service users at increased risks as staff did not have the skills, knowledge, or training to provide safe care.
● Staff competence and skill was not monitored. The provider told us they assessed staff competence by completing spot checks. However, only 19 spot checks had been carried out since November 2022. During these checks, multiple concerns were noted about staff practice and competency with limited action taken to support further training.
● We received mixed feedback from people and their relatives. We heard, "I think they are well trained" and "Most of them do [know how to support person], there are a few that need more training." However, we also heard, "I just don't feel all the carers have the same standard of care, for example, some of them are really good at putting on her elastic stockings and others aren't."

Staff were not provided with appropriate support, training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did not receive regular supervision to support their professional development. During the inspection we asked for a sample of 10 supervision records. After the inspection we were shown 3 documents of supervision, 1 from after the inspection date and 2 from earlier on in the year. These did not match the dates on the matrix or were not available on the matrix and there was no evidence of supervision prior to April 2023. Some staff we spoke to confirmed they had not had any supervisions. Therefore, we were not assured supervision was being carried out effectively.
● We heard from people using the service they had concerns about staffing and their hours. A person using the service told us, "Staff get picked up at 06.40 am and dropped back home 10 pm. Their break is spent in car as all don't drive". Staff confirmed they often work long hours but only get paid for the visit times to people's homes. They were not paid for travel between these visits. This meant that staff often worked long hours but only received 4 hours pay.

Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's needs were not always assessed to ensure they received safe care and treatment as care plans did not always contain information regarding their meal and drink preferences and what support was required.
● For 2 people using the service, they required support with their nutritional intake. One person's care plan documented they were required to take daily nutritional supplements. There was no further information within their nutrition and hydration care plan. Within the assessment under nutrition, it contained another person's name. Another person's care plan documented they were to be supported to have a nutritional supplement in the evening. However, this was not listed to be done in the visit care tasks section of the care plan. In addition, there was no information about why the nutritional supplement was required. Records showed this supplement had only been given once over a 14-day period
● A person's care plan documented they required support only with their morning meal. There was no further information listed for other visits during the day about supporting the person with meals despite the care notes stating the person had support at each visit with meal preparation.
● Another person's care plan documented their ability to prepare their own meals. Care notes did not detail prepared meals. Staff we spoke with confirmed the person was unable to prepare their meals anymore and

this is completed by staff. This lack of information could result in the person not receiving the support required to maintain adequate nutrition and hydration.
● We heard from a person using the service, "[They had] ready meals [prepared] in the microwave. Sometimes they [staff] get the times of the food wrong and it can be uncooked. If I tell them they will put it back in the microwave."

The failure to assess a service user's nutritional and hydration needs, was a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Person Centred Care

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some people received input from a variety of health and social care specialists such as dietitians, occupational therapists and speech and language therapists in response to their specific needs.
● A person's care plan detailed they received a podiatry visit every 6 to 8 weeks. Live in care staff confirmed this person had not received any podiatry support within the last 3 months. The care plan did not detail the need for these podiatry appointments, the risk of not having these appointments, or whose responsibly it was to arrange these appointments.
● The service worked with Home First [a collaboration involving local health and social care providers]. Prior to inspection we had received information about concerns raised by Home First with the service provider around people's documentation. Although the service no longer worked with Home First, there was limited evidence available that all the concerns raised by the service had been recorded or responded to ensure the service provided effective care.

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.

● The requirements of the MCA and the need to consider the least restrictive options when developing people's plans of care had not been implemented. Consent to treatment was not always obtained, evidenced or effective.
● There was limited documentation in place to support and evidence people were involved in decisions about their own health care. This included risk assessments and mitigations around decisions made by people about their care.
● Documentation evidenced that 5 people using the service may have lacked capacity due to a cognitive impairment however, the provider had made no attempts to have assessments completed for their capacity. There was no documentation available to evidence people or their next of kin with relevant authorisation had given consent to care.

● Staff were not all able to describe the principles of the MCA and how this impacted on their work. Whilst some staff were able to demonstrate their knowledge, some staff told us they had not received training and others were unable to understand our questions.

The failure work within the requirements of the Mental Capacity Act 2005, was a breach of Regulation 9 (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Person centred care.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● We were not always assured the service treated people with respect and promoted people's privacy, dignity and independence.
● Care plans and risk assessments did not contain accurate information about people's abilities, and how best to support people to maintain their independence. Multiple care plans contained identical information around encouraging and assisting support tasks. However, these were not specific to people needs or support. A person's care plan stated, "I wish to remain independent as much I can" and "I would like assistance to wash areas I cannot reach." There was no further information available that would allow staff to appropriately support this person to maintain their independence.
● Spot checks carried out on staff raised concerns regarding staff's ability to communicate with clients, gain consent, and people's dignity not being respected. We could not see any action to support staff with further training.
● We received mixed reviews from people using the service and their relatives. We heard, "They [staff] all treat [relative] with kindness and respect" and "They [staff] are absolutely kind and sweet to me." However, we also heard, "The male carers are a bit messy and they had left a towel that had urine on it in the bedroom. It doesn't happen often, but they are a bit careless."
● Staff told us they do not see regular people. We heard people using the service were not informed about staff changes, and did not know who was coming as they do not work in the same areas or have regular clients [people].

The failure to meet people's needs, and reflect their preferences, was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Person Centred Care

Ensuring people are well treated and supported; respecting equality and diversity
● Some people who used the service told us they received kind and compassionate care. We also heard, "Yes, [staff were caring] only problem is they hurry for the next person." Our findings did not suggest a consistently caring service due to a lack of clear oversight of the service provided and systems which did not effectively keep people safe.
● There was limited equality and diversity information available regarding the people who used the service. The care plans reviewed did not evidence that people were asked if there was a gender preference for care staff and did not provide detailed information about religion or culture.
● We heard from people using the service and their relatives, "Sometimes [staff] forget little things for [person] such as leaving [person's] reading light on or putting [person's] book in front of [person] so [person]

can read. It's important to [person]. I do leave notes for [staff] to remind them and although they do their best it's just a bit worrying for me. [Person] loves them all though and that's the main thing."

● Despite comments regarding the kindness of individual staff members, the widespread shortfalls and lack of personalised care identified throughout this report meant the approach of the service could not be considered as caring.

The failure to meet people's needs, and reflect their preferences, was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Person Centred Care

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

● The service did not effectively act on feedback. Multiple concerns and complaints had been raised by people, but there was no action or acknowledgement recorded that these had been responded to.

● The service was unable to provide evidence people were supported to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible. Care plans we reviewed were not signed by the person and there was no record of people being involved with developing their care plans. Where family were involved, relevant information about power of attorney was not available.

● Some people using the service told us they were sent a survey to complete regarding the care provision. We heard from a person using the service, "I think I was involved in the care plan, but it was a while ago now. I can't remember if the office ever rings to ask if everything is ok, but it is."

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 good. 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

- People did not always receive personalised care that met their preferences. Where care plans had been completed, there was a lack of detailed information regarding people's needs, preferences, likes, dislikes and life histories. This increased the risk staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life. This was of particular concern as people did not always receive their care from consistent staff.
- Initial assessment information was not considered within people's care plans. For 1 people using the service initial referral information was not considered within their care plan. They had specified they wished to only have female care staff. This was not documented within the care plan, and they were refusing care due to males supporting them with their care.
- Information within care plans and risk assessments was not consistent. Information on areas including skin integrity, mobility and continence needs differed in different documents and there was no additional guidance available contained within care plans or assessment for staff to follow.
- Care plans did not contain enough information about people's needs or reflect best practice guidance. Records were often standardised in several aspects of the care plan, including for information around people's wellbeing. There was no guidance or information available about how to support individuals with their psychological needs and there was no supporting capacity assessments or information around people's capacity and consent.
- Care plans were not consistently reviewed as people's needs changed. The care plan review spreadsheet did not contain all people using the service. One person's care plan review was documented as being carried out as yearly instead of 6 monthly as specified by the service. Another person's care plan was documented as not being reviewed for 2 years. We heard from 1 relative, "I have not had any 6 monthly reviews in the 2 years [person] has been having support."
- Staff did not always recognise when a person was unwell and required additional support such as an ambulance. Not all care staff always recorded the support they provided correctly. For example, care records were not always reflective of how people were feeling or did not provide enough information to assess people's wellbeing and needs.

The failure to ensure care plans were completed which reflected people's needs, preferences and end of life care wishes was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● The provider could not evidence how they were embedding and meeting people's communication needs due to the lack of care documentation around communication available.
● One person's initial assessment detailed they were sight and hearing impaired, there was no care plan in place for communication.
● Another person's care plan documented they used equipment such as eye gaze to communicate, there was no training seen to evidence this.

Improving care quality in response to complaints or concerns
● Systems and processes were ineffective in identifying any trends or patterns in incidents, accidents and complaints, as these were not always recorded.
● The complaints log did not contain any complaints raised by service users and their family. This log contained complaints raised by professionals. There was not always evidence these were responded to or investigated adequately.
● Feedback the provider had collected from people using the service detailed concerns and complaints. These were not recorded on the complaints log. Some actions within the feedback log detailed some action had been taken however, did not contain dates. For 18 points which contained poor feedback there was no action detail or acknowledgement.
● People and their relative's mainly felt concerns were dealt with. However, they commented it was difficult to get through to the office. We also heard, "The times for [person's] visits are not always good either. Sometimes [person] gets first call at 9 and then the lunch visit is at 11:45 and [person] doesn't feel hungry as it hasn't been long since breakfast. We have had several meetings with the company, and they sort it for a while but then staff change, and it reverts back again."

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● Care plans did not contain information in relation to the care and support people wished to receive at the end of their life.
● A person's care plan documented under 'Ensure comfort and provide assurance during end-of-life Care' detailed 'Give personal Care communicate effective, provide reassurance, give accurate care notes so the correct medical intervention can be obtained'. There was no other information available to indicate this person was receiving 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 requires improvement. At this inspection the rating has changed to 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

- We received mixed feedback from staff regarding management of the service. We heard "Yes, the manager is supportive. Sometimes she will call you to see how things are going/how work is going." However, we also heard people did not feel able to approach management and did not feel supported, "Management don't ask about us, they are only interested in the work, they don't care" and "I don't feel supported they don't look at me as an individual, only a worker."
- People and their relatives using the service did not always know who the manager was. We heard "I don't know who the manager is" and "I find management easy to talk with although I am not sure who the manager is."
- The system to ensure safe management of medicines was ineffective, as the provider failed to ensure people received their medicines safety.
- The provider failed to have systems to monitor the content of risk assessments and care plans. Staff did not have clear guidance from care plans and risk assessments on how to support service users safely. This put people at risk of harm.
- The provider failed to implement an appropriate system to monitor, evaluate and ensure people's needs were met by staff with appropriate knowledge and skills to meet their needs.
- The provider failed to have effective accurate oversight of records for supervisions, spot checks, and appraisals.
- Audits were not effective in driving service improvement. Audits were not always accurate, and they did not identify the shortfalls we found during inspection.
- Staff meetings did not discuss incidents and the service development plan did not contain dates; therefore, it was unclear how these were being monitored.
- We found from documentation and speaking to people, the service did not always promote a person-centred approach. People's individual needs were not always considered or met.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Good Governance .

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Lack of management oversight had contributed to the shortfalls identified. The provider had failed to

ensure good quality assurance systems and processes were maintained and this meant the service lacked effective improvement.

● Care records and risk assessments required more detail to ensure information was detailed and current for staff to refer to. The provider's lack of audits had failed to identify shortfalls found around medicines and the lack of information for safe administration in care plans.

● The provider did not have effective quality assurance systems and processes in place designed to enable them monitor and improve the safety and quality of people's care. Although there were records that reviews of care plans, care notes and risk assessments had taken place, we found them not to be effective as the concerns we found had not been addressed or identified. This included inaccurate information in care plans, lack of information for staff to follow and risk assessments which were not always robust or in place. Audits evidenced they had been created after the inspection and did not contain accurate information.

● The service did not have a robust system to monitor care visits. There was no clear system to identify when care visits were late or missed. The manager told us they could download call histories; however, we did not see any evidence this took place and whose responsibility this was. People using the service told us, "No [person does not receive the full allocated time as] they [staff] want to rush off sometimes" and "The problem is between teatime to evening call - Teatime is 5.00 and evening is supposed to be 9pm and sometimes they can come at 7pm."

● We could not be assured the system used for staff to log in and out of calls and record their notes was safe. Staff notes could be uploaded when not in attendance due to not having sufficient mobile data. This meant there were no assurances staff attended the calls on time or for the correct length of time.

● The registered manager did not understand the need to notify us about relevant changes, events and incidents affecting the service and people who used it. We did not receive notification from the service around people's safety or where safeguarding had been raised. The registered manager told us they had copied in the commission when raising safeguarding. We saw on some occasions the provider had copied in an CQC safeguarding email address, that sent an automatic reply stating that it was intended for the use of the local authority to use. The provider had previously been made aware of the importance in notifying the commission during their last inspection.

● The staff we spoke with were not always clear about their respective roles and responsibilities and what was expected of them. Staff did not always feel safe to raise concerns with management about people's safety.

● Complaints which the provider had recorded did not include complaints people and their relatives had made within service user feedback.

● Incidents which had been recorded did not demonstrate appropriate action had been taken in relation to these concerns. There was no evidence care plans and risk assessments had been updated.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider failed to notify the appropriate authorities of events and incidents which impacted people. Records showed there had been a delay in reporting a number of safeguarding incidents to the appropriate authority and CQC were not notified about these events.

● The registered manager told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care. However, the lack and delay of investigations following incidents, poor communication, delay in reporting of notifiable incidents and safeguarding concerns indicated the provider was not fully aware of their responsibilities

under the duty of candour.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service evidenced people using the service were asked for feedback. However, we found feedback provided by people using the service was not reviewed to identify learning for the service and issues to be addressed in a timely way to prevent recurring issues.
- Staff told us they did not always feel able to raise any concerns. We heard, "If you raise issues with the company, they then say you do bad care. The manager is not good. I can't raise issues with them" and "I complain but nothing done. Everyone says don't complain as nothing done" and "I wouldn't raise concerns as I am not confident [that it would be dealt with]."
- Staff feedback was not always acted upon to continuously improve the service. The staff survey from 2023 provided some negative responses. There was no action seen to follow this up or gather more information in order to establish where improvements could be made.
- We heard from a relative of someone using the service, since using the service they had only received 1 feedback form "Changes did get put in place as a result of the feedback but then it goes back to normal when the staff change again."

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team were receptive to our feedback from the inspection. Following our inspection, they were asked to share an action log to address these concerns.

Working in partnership with others

- The provider told us they understood the need to work in partnership with and share information with other agencies, including the local authority and community health and social care professionals, to ensure people received joined-up care. However, we did not always see the provider had responded to or acted upon concerns raised by other agencies.
- The provider had been working with the Oxfordshire County Council (OCC) quality team prior to our inspection. OCC had carried out an analysis of the service and informed the service of their concerns around care planning and risk assessments. The service was aware of similar findings we found during this inspection and had not demonstrated appropriate action had been taken to make improvements to the service.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.