Passionate About Care Ltd

Havant & Petersfield

Inspection report

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Date of inspection visit:
23 July 2021

Date of publication:
18 October 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Havant & Petersfield is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 88 people at the time of the inspection, including older people, those living with dementia, people with a physical disability and younger adults.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. 60 people were supported with personal care at the time of the inspection.

People's experience of using this service and what we found
Medicines were not managed safely. There was a lack of oversight of medicine administration and medicine records were not always complete. We were not assured people always received their medicines as prescribed.

Risks to people's health and wellbeing had not always been assessed, monitored or mitigated effectively. People were at risk of harm because staff did not always have the information they needed to support people safely.

The provider had not established an effective system to ensure people were protected from the risk of abuse. Accidents and incidents were not appropriately reported, and actions were not always taken to ensure the safety of people.

Staff were not recruited safely. This meant people were potentially at risk of staff being employed to work with them who were not suitable. Staff were not always appropriately deployed to ensure people received support in a timely way that met their needs and preferences. Staff had not received all the training required to support people using the service and people and their relatives provided a mixed view regarding the skills of staff.

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

People did not always receive person centred care. A care plan was not in place when one person required end of life care. This meant staff did not have information about how best to support them at this time in their preferred way. There was a lack of understanding about the Accessible Information Act and improvements were needed to ensure people were supported with their communication needs effectively. Not all people were supported to receive their care visits at a time they preferred.

Improvements were needed with the management of complaints. We have made a recommendation about

this.

The service was not well led. The provider did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified concerns or driven sufficient improvement relating to service quality. Records were not always complete. The lack of robust quality assurance meant people were at risk of receiving poor quality care.

Most people and relatives were positive about the caring nature of the staff who supported them and felt they were treated with respect and dignity by them.

Following the inspection, the provider acknowledged the concerns that we identified during the inspection and told us of their plans to make improvements.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 10 January 2020). There was one breach of regulation in relation to the provider not notifying CQC of incidents they were required to do so. The provider sent us an action plan to show what they would do and by when to improve.

Since this rating was awarded, the provider has altered its legal entity. The service has changed its location name from Passionate About to Care to Havant & Petersfield. It has also changed the location of the premises. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

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

Why we inspected
The inspection was prompted in part due to concerns received about call times, training, infection control and the management of complaints. A decision was made for us to inspect and examine those risks. The inspection was additionally carried out based on the date the provider altered its legal entity.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, responsive and well-led sections of the full report.

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

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

We have identified breaches in relation to medicines management, risk management, safeguarding, consent, governance, person centred care and staffing.

Follow up
We have imposed a condition on the providers registration which requires them to submit a monthly report to the Care Quality Commission on the actions being taken to ensure improvements are being made to quality and safety of the service.

We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Havant & Petersfield

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by an inspector, an assistant inspector and an Expert 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.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager who had been in post for approximately three weeks at the time of the inspection. They intended to register with the Care Quality Commission. We refer to this person as the manager throughout the report.

Notice of inspection
We gave a short period notice of the inspection. This was because we needed to be sure that a member of the management team would be in the office to support the inspection. Inspection activity started on 21 July 2021 and ended on 29 July 2021. We visited the office location on 23 July 2021.

What we did before the inspection
Before the inspection we reviewed the information we had received about the service, including notifications. The provider completed a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. However, this was not reviewed by CQC prior to the

inspection. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and seven relatives about their experience of the care provided. We spoke with 13 members of staff including the manager, care manager, care coordinators, care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Risks associated with people's support needs and health conditions were not always assessed, monitored or plans to reduce the risks implemented effectively.
• Where people lived with a particular health condition, there was not an associated care plan or risk assessment in place which provided effective guidance for staff on how to support them. We additionally found staff did not always have appropriate knowledge about the risks associated with these conditions. For example, some people lived with diabetes. This can cause people to experience too high or too low sugar levels in their blood and require medical attention. There was no recorded guidance for staff about this and we found some staff were not aware of how to recognise or act on the signs of a person's blood sugar levels being too high or low. This meant people may be at risk of not being supported appropriately with their health conditions or receiving medical attention when needed.
• Other people received support from care workers to manage the care of their catheter. Catheters are tubes used to drain a person's urine into an external bag. These can be prone to blocking and there is a higher chance that a person with a catheter will get an infection. There was no information in the care and support plan to guide care workers on how to provide safe catheter care whilst also reducing any risks of infection.
• Daily records demonstrated that one person sometimes displayed distressed behaviours. A staff member told us, "Not everyone can get on with [Person's name]. She can be a tricky customer if she's having a down day and she's been getting them." We additionally saw an entry in the person's daily records where the staff member was unable to provide support to them because they were 'violent'. However, there was no information in the care plan which would guide staff about any triggers to behaviours so they could reduce the risk of the behaviours presenting, and no information which would guide staff about how they manage the behaviours if they presented This meant the person and others were placed at risk of harm.
• This person was also prescribed the use of bed rails to maintain their safety when in bed. The use of bedrails can present additional risks to a person's safety such as a potential increased risk of entrapment of the body or limbs. However, there was no guidance for staff to ensure this person's safety when using bed rails.
• Where risk assessments were in place, they were not always detailed and lacked guidance for staff on how to manage or reduce risks for people. For example, moving and handling risk assessments stated how many staff were needed to support a person and what equipment they may need but there was no information about what actions the staff needed to take or how to use the equipment. Not all staff had received sufficient moving and handling training in relation to the equipment people used. This put people at the risk of harm.
• Furthermore, risk assessments were not always reflective of people's needs. For example, one person had a

moving and handling risk assessment in place which specified what equipment they needed to use to move safely. However, when we spoke with a staff member, they told us they no longer used this equipment and the person stayed in bed all of the time.

The failure to ensure the safe management of risks and take all reasonably practicable steps to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the manager told of their plans to address the concerns regarding risk management. However, these improvements needed to be embedded and sustained to ensure risks were consistently managed in a safe way.

Using medicines safely
• Medicines were not safely managed.
• Information and guidance for staff about people's medicines was either not in place or was unclear. For example, one person's MAR did not include the name of the medicines the person had been prescribed. Instead, it stated the number of tablets that staff should give, and staff recorded the number of tablets they provided. This meant tablets were being administered by staff who did not know what they were, what they were for and if they should be monitoring for any effects. For another person, records demonstrated they were prescribed a medicine to be taken twice a day, but they were only given it once a day. The management team had not recognised this and were unable to explain the reason for this at the time of our site visit. Following the inspection, they told us this person's medicines had been changed but the MAR had not.
• We were not assured people had received their medication in line with their prescriptions because staff had not always documented they had administered these. For example, on one person's MAR, it stated they should be given six tablets in the morning, but we saw they were given five, six and seven tablets on different days. This meant we could not be assured they had taken the medicines they had been prescribed. Following the inspection, the manager told us the reasons for this and concluded the person had received their medicines appropriately. They also put detailed MARs in place to demonstrate what medicines had been administered.
• For another person we found they had 74 gaps on their MARs for June 2021, suggesting they had not been given their medicine on 74 occasions. There was no recorded explanation for the gaps in the administration records and the management were not able to provide an explanation. No investigation had been completed and the management were unaware of this until we highlighted it to them. The manager completed an investigation following our feedback. They concluded the gaps were caused by an error with the electronic system and people had received their medicines as prescribed. However, we were not assured that the system had caused all of the gaps due to the high number of them and conflicting information in people's care records.
• At our last inspection we identified there were no protocols in place for people who were prescribed medicines 'as required' (PRN). This meant staff did not have guidance to administer these medicines effectively as is best practice considered by The National Institute for Health and Care Excellence (NICE). We made a recommendation about this. At this inspection we found PRN protocols still had not been implemented. This meant people may not receive their PRN medicines appropriately and placed people at the risk of harm.
• Topical creams were not always safely managed. For example, one person's care records demonstrated they had been prescribed a topical cream to help alleviate a skin condition. This cream had not been added on to the MAR although daily records stated it had been applied on some occasions. However, on other occasions staff had applied two other different creams to the area even though they had not been prescribed for this use. This meant the person was not being supported effectively with their skin condition.

• One person's medicines were being administered by a district nurse. However, we found that care staff were signing to say they had administered this medicine. Staff should not sign for a medicine they have not given as this causes a potential risk of confusion regarding medicines and increases the risk of error.

The failure to ensure the safe and proper management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the manager told us of their plans to ensure the management of medicines was safe. However, these improvements needed to be embedded and sustained to ensure medicines were consistently managed in a safe way.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes were not always effective in protecting people from the risk of abuse.
• The service had a detailed safeguarding policy in place; however, this had not always been followed or understood by staff. Two professionals told us safeguarding concerns were not always raised to the safeguarding team in a timely way. They also told us that investigations into safeguarding concerns were not always carried out in a robust or timely way by the provider when they were asked to do so. This put people at increased risk of harm.
• Staff told us they locked one person in their house. They also described the person becoming distressed, tapping on the windows and trying to "escape". As the person's care plan stated, 'I do have capacity to make my own choices within my care/life choices', it was not clear why they were being locked in their house when they demonstrated they did not want to be. Staff told us they did this to prevent the person from coming to harm. However, we were concerned that this person may be being deprived of their liberty without any lawful authority. This meant this person's human rights may be being compromised. Following the inspection, we made the safeguarding team aware. They carried out a review and told us this person was able to freely leave their house. However, we remained concerned that staff had not taken action when they thought they were locking a person in their house against their will.
• Approximately 70% staff had undertaken safeguarding adults training. However, not all staff had a robust understanding of safeguarding adults. Some staff could not remember whether they had received safeguarding training, how to recognise the signs that someone was at risk of abuse or harm or what action to take if they thought someone had been abused or harmed.

The failure to safeguard users from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite this, most people and relatives felt safe with the staff who supported them.

Learning lessons when things go wrong
• The provider did not have an effective system in place to monitor accidents and incidents, or to identify any patterns or trends.
• Some accidents and incidents were recorded in daily records but due to the lack of monitoring of these, they often got missed by staff in a senior position or the provider. There was no evidence any investigations had taken place, analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again. This meant lessons were not learnt when things went wrong.
•The lack of oversight meant the provider was unaware of safety concerns in the service such as medicine errors and a person being unlawfully locked in their house.

A failure to have systems in place to assess, monitor and improve the quality and safety of the service was a

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

Recruitment
• Staff had not been safely recruited.
• We looked at six staff records and found concerns about all of them. Recruitment records did not demonstrate that all appropriate pre employment checks were completed before staff started work.
•The provider had not checked any of the staff members DBS's prior to employment. DBS checks enable employers to check the criminal records of potential employees and are important to enable them to make safer recruitment decisions.
• The provider told us staff who did not have a DBS check worked alongside experienced staff members until a suitable DBS check was received. However, the information we received from the provider did not assure us of this. This was because records were not always complete and contained conflicting information.
•The provider told us DBS's had been received for staff after their start date.However, they were unable to provide sufficient evidence of this for all of the staff members.
• Information, including references and interview records did not always provide assurance that prospective staff members were of good character or had the necessary competence and skills to carry out their role. For example, one staff members reference stated they would not re-employ them and we were not provided with evidence that this had been investigated. Another staff members' reference had been written by a staff member already employed at the organisation. Additionally, interview questions did not ensure staff would be suitable for the role they applied for.
• Application forms had not always been fully completed and gaps in staff's employment history had not been noted or explored further on interview. This meant the provider could not be assured staff members were suitable to work with vulnerable adults.
• We discussed our concerns about safe recruitment practices with the nominated individual who told us they had recruited staff, without all of the usual checks because they needed staff urgently at the time of the COVID-19 pandemic. However, this was not line with CQC guidance or their own policy.

The failure to ensure fit and proper persons were employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Staffing
• Prior to our inspection we received a concern about times of care visits in relation to people's medicines. At this inspection we found a person had not always been given their medicine as prescribed because there was not enough of a gap between care visits. If a person does not receive medicines as prescribed, they can become unwell. We discussed this with the manager who told us they would be putting measures in place to ensure this person had visits in line with the times they needed their medicines. The service was unable to provide evidence of this because the day after our site visit, the person was no longer in receipt of their care.
• Some people and relatives told us they did not always receive a reliable service and staff did not arrive when they expected them to. Comments included, "The timings are not great, and I'd say the care is not consistent and the service is not good at all." and, "I have asked many times if we could change the time as they (staff) come too late, but nothing has happened yet."
• Some people and relatives also told us that improvements were needed with continuity of staff. For example, one person told us, "There is such a huge turnover of carers and I never know where I am with them." Other people described feeling rushed at times.
• We reviewed records of call logs and these showed a number of discrepancies between agreed hours and actual hours delivered. For example, one person received calls that were outside of a half an hour window of their agreed time on 19 occasions in a two-week period. We also saw that staff had not stayed for the allocated time on most visits. Over the two-week period this equated to approximately five and a half hours of care that was not provided in line with the agreed hours.

• Despite this, most staff told us they could get to people on time and stay for the allocated length of time. However, they did say they needed more staff.
• We asked how call times were monitored. The care manager said they had a system which told them if staff had arrived too late or did not stay for the allocated time. However, this was not analysed over any time period so themes or patterns could be identified. We additionally could not see that any action had been taken in response to people's requests for different times.
•Following the inspection, the local authority carried out reviews with some people. They found that one person who was allocated to have two staff members to support them was only receiving support from one staff member on some occasions.

The failure to ensure staff are sufficiently deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When we discussed these concerns with the nominated individual, they told us they felt they were partly due to the pandemic and that it had been difficult to recruit staff. They went on to say they now had enough staff and would review call times. They also confirmed they would not be taking on any more care packages until they were confident people could be supported appropriately.
• Other people and relatives we spoke with were happy with the arrangements of their care calls. For example, one person told us, "They [staff] visit when I want and what's more turn up on time for most visits."

Preventing and controlling infection
• Prior to the inspection we received a concern that staff were not wearing personal protective equipment (PPE) when carrying out care. We discussed this with the manager during our visit to the office. They told us they were aware of this concern and had implemented measures to ensure staff wore the correct PPE. This included reminding staff of the importance of wearing PPE, carrying out spot checks and gathering feedback from people and their relatives.
• With the exception of one person, people and relatives told us that staff supported them in a way that was hygienic and minimised the spread of infection. For example, one relative told us, "The wearing of masks and all the protection has been pretty good."
• Staff told us they used personal protective equipment and understood the importance of hand hygiene.
• The provider had a policy in place to guide staff about safe ways to work during the COVID-19 pandemic. Staff told us they undertook weekly testing to ensure they did not have COVID-19. The provider did not have evidence of this but told us they would ask staff for evidence going forward to assure themselves of staff members COVID-19 status before they visited people.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

• People were not supported in line with the principles of the MCA.
• Where there were doubts about people's decision-making capacity, mental capacity assessments were not always in place to determine people's level of capacity to make decisions. This meant people may not be supported to make decisions in an effective way.
• Where mental capacity assessments were in place, they were not decision specific as outlined in the MCA and did not contain detail of how the assessment had been completed. Records about people's capacity and decision-making ability were conflicting. This meant assessments were not effective in assessing a person's capacity to make a specific decision.
• Where a person lacks capacity to make a decision, any decisions made on their behalf should be in their best interests. However, the manager told us best interest processes were not followed. For example, one person needed support with their nutritional needs. The care plan stated staff must not follow their wishes about what food they had but those of a relative who did not have the legal authority to do so. Staff told us how this had a negative impact on the person's well-being. As stated in the safe section of this report, another person was being unlawfully deprived of their liberty. There were no records in place which demonstrated the principles of the MCA had been followed in these instances.
• Staff did not have a good understanding of the MCA. For example, the care manager had changed a mental capacity assessment retrospectively. They did not understand that assessing a person's capacity to make a decision should be decision and time specific. Other staff members were unable to explain what the MCA was or how they applied the principles in their day to day work.

The failure to follow the principles of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
• Two professionals told us the service did not always escalate concerns about people to health and social care professionals when the need was there.
• We saw an example of staff not acting in a timely way when a person was showing signs of a urine infection at the beginning of June 2021. No action had been taken until the end of June 2021 when a professional asked for their urine to be checked for signs of infection. This was despite the person falling and displaying signs of confusion and agitation in the meantime. Urine infections can cause these symptoms. When we discussed this with the manager, they told us they would implement a system where staff reported concerns to the management team so appropriate action could be taken to support people with their health needs.
• We saw another entry in this person's daily records which stated, 'Leg is elevated as advised by DN (district nurse)'. We could not see any information in the care plan about the need for this persons' leg to be elevated or that any other staff member had done so. When we discussed this with the manager and care manager, they did not know what this was about. This meant guidance from health professionals was not always followed by staff. The manager told us they would implement a system where guidance from professionals would be included in people's care plans so all staff could follow this.
• The care manager told us they were proud of the relationship they were building with social workers and felt this would support joined up care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care needs were assessed before they began being supported by the service. However, when people's needs changed, their care plans were not always updated. This meant staff did not always have accurate information about how people's needs could be met.
• Although people's needs in relation to their protected characteristics had not always been included on their assessments, the manager assured us that discrimination of any kind would not be tolerated. People did not tell us anything to contradict this.
• Best practice guidance was not always utilised which meant practice was not always consistent. For example, nationally recognised tools to assess people's skin integrity and nutritional status were used to assess some people's needs but not others. The manager told us they would be using these tools with all people in the future.
• Current guidance in relation to the MCA was not being followed because staff lacked an understanding about it.

Staff support: induction, training, skills and experience
• People and relatives expressed mixed views about the skills and experience of staff. Comments included, "I am sure they [staff] are very well trained; I've had no problems at all", "Some [staff] seem to be well trained some don't" and, "I'd say their training is not adequate. The training is not thorough enough; they're not investing in their staff."
• We reviewed the providers training matrix. This demonstrated not all staff had undertaken training that the provider deemed to be necessary for their role. For example, approximately 30 percent of staff had not undertaken safeguarding or infection control training and approximately 20 percent of staff had not undertaken training in moving and handling people safely.
• We additionally identified that more in-depth training was not always provided for staff following the induction training. This was the case in areas such as safeguarding adults and infection control training. This meant staff may not have been provided with the opportunity to develop their knowledge and skills.
• Although staff told us they had received enough training, we found some staff lacked an understanding

regarding some areas such as safeguarding, the MCA and people's health conditions.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• The nominated individual told us they had needed to stop face to face training for staff due to the pandemic and they had plans in place to develop the skills of their staff. For example, they had secured 11 places so staff could be enrolled on a national care qualification. They also told us they would be moving back to more face to face training once the pandemic was over to increase staffs understanding.
• Most new staff were provided with an induction which was in line with the Care Certificate. The Care Certificate induction standards are nationally recognised standards of care, which staff new to care are expected to adhere to in their daily working life to support them to deliver safe and effective care. Staff told us they received an adequate induction which enabled them to confidently support people. This included shadowing more experienced staff members as part of their induction.
• Staff told us they were supported through formal supervision and also through informal means. All staff said the nominated individual, manager and care manager were approachable and would help out with anything that was needed.

Supporting people to eat and drink enough to maintain a balanced diet
• People and relatives provided us with a mixed view about the support people received with their eating and drinking needs.
• Care plans did not always provide staff with detailed guidance about the support people needed with eating and drinking. For example, one person's care plan stated, 'If I am in bed the carer will need to ensure I am in a good position, so I don't choke.' However, it did not state what a good position meant. Staff who often supported people had a good idea of their needs but staff unfamiliar with people would need detailed information in care plans to keep people safe and ensure their nutritional needs were met.
• Other care plans were more detailed and contained information about people's preferences.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
• As detailed in the Effective section of the report, people were not always appropriately supported to consent to all aspects of their care.
• Consent forms were in place to demonstrate people had consented to the care provided to them. However, these did not always include sufficient information to evidence people had the capacity to consent to their care or relatives had the legal authority to do so. This meant it was not always clear whether people had agreed to all aspects of care provision.
• People did not always feel well-supported in a way they preferred. For example, one person told us, "They (staff) don't always understand my needs, or I wouldn't be left uncomfortable, would I?"
• People's preferences had not always been considered. People were not always able to choose what times during the day they received their care call or who supported them. For example, one person told us, "I have complained about timing, like today, I am waiting to go out and they (staff) still have not arrived at 10.30am. I have to put my life on hold for them." Some people felt they did not always have a choice about who supported them. One person told us, "There is just no continuity and they are always changing [staff] so a bond can't be formed."

The failure to support people in a person-centred way was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

• The care manager had recently organised for reviews to take place with people to enable them to express their views about their care. We reviewed a sample of these and found feedback about people's care was predominantly positive. However, the reviews had not reflected some of the feedback we gathered during our inspection. This indicated this method of gathering people's feedback was not always effective.

Ensuring people are well treated and supported; respecting equality and diversity
• The providers lack of some systems and processes meant that people may be at risk of receiving care that did not meet their needs. This has been further detailed in the safe, effective and responsive domains of this report.
• Despite this, most people and their relatives provided positive feedback about the caring nature of the staff. Comments included, "They are so kind and caring and very polite and gentle." and "I feel they actually really do care about me and that makes me happy."
• Staff spoke fondly about the people they supported. We asked staff what the best thing about working at

Havant & Petersfield and one staff member told us, "Looking after my clients, making them smile and laugh. I just want to keep them happy and it's lovely seeing them smiling when I leave."
• Some of people's protected characteristics had been considered as part of their care planning. For example, we saw a person's religious needs were respected and met. However, people's needs in relation to their sexuality usually had N/A recorded in this section of the care plan. The manager told us they were unsure why this was and would aim to include this information in the future. This would ensure people would be supported in line with their needs and preferences. People were able to choose whether they were supported by female or male carers and we saw these wishes were followed.

Respecting and promoting people's privacy, dignity and independence
• Staff were able to tell us how they would protect people's privacy and gave examples such as closing doors when assisting with personal care. Most people felt their privacy and dignity was protected. For example, one person told us, "I don't get at all shy, they make it all so easy for me."
• Staff described how they supported people to be as independent as they could be. For example, one staff member told us, "I want to help but [Person's name] doesn't want it so I let her be as independent as she can be.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• There was not a robust system in place to update care plans when people's needs had changed. There were numerous examples of care plans which were not reflective of people's current needs. On one person's care plan it stated, 'I am lucky to have good skin, I do not need creams to be applied.' And 'I do not wear continence pads.' However, staff have recorded in daily records they had been applying creams and supporting the person with their continence pad. For another person, the care plan did not contain any details about the person's catheter, but daily records demonstrated, and staff told us this person had one. The lack of accurate information in people's care plan placed them at risk of receiving inappropriate care.

• Furthermore, care plans were not sufficiently detailed in order for staff to provide people with personalised care. For example, one person's care plan stated they needed support with personal care but did not detail what support this consisted of. Another person's care plan stated they often felt depressed and anxious but there was no detail in the person's care about how staff could support with this.

• Most relatives told us staff knew people well and supported them in line with their needs and preferences. However, people sometimes needed to be supported by unfamiliar care workers and they would need to rely on the information in people's care plans. The lack of personalised detail in people's care plans posed a risk that they would not have sufficient information about how to support people in line with their needs and preferences.

The failure to maintain an accurate, complete and contemporaneous record in respect of each service user was a was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We discussed our concerns about the lack of accurate and personalised information in care plans with the manager. They told us they would be undertaking some work to ensure the care plans held accurate, detailed and personalised information.

• The care manager told us they involved people and their relatives when they carried out the initial assessment. This was reviewed 6-8 weeks later to check they were happy with the care provided. However, people's care needs were not routinely reviewed for a year after this. This went some way to explain the lack of accurate information in people's care records. The manager told us they would carrying out reviews more often.

Meeting people's communication needs: End of life care and support

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Care plans contained a section about people's communication needs but these were not always sufficiently detailed for staff to know the best way to communicate with people. For example, one person's care plan stated, 'Communicates verbally and non-verbally'. There was no additional detail to support staff to understand what non-verbal communication the person used. Another person's care plan stated, 'I find it hard to verbally communicate and sometimes I get frustrated'. However, there was no information about what other methods could be used to communicate with the person. This meant people may not be supported in the most effective way with their communication needs.
• When we asked the manager and care manager how they adhered to the accessible information standard they lacked an understanding of what this meant and were not able to provide any examples of how this act was adhered to.
• People did not have end of life care plans in place when they were receiving end of life care. This meant that staff were not aware of people's preferences at this time.
• Staff had not received training on end of life care, however, the manager told us healthcare professionals were involved as appropriate.

The failure to provide service users with person centred care was a 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
• Some people told us they had made complaints to staff in the office. However, when we reviewed the complaints file, no complaints had been recorded since July 2020.
• We discussed this with the nominated individual, manager and care manager and they told us that feedback which had been received in this way had not been treated as a formal complaint so was not recorded.
• Some people and relatives told us they had not always felt listened to and no action had been taken by managers following receipt of the feedback. Therefore, the provider had missed opportunities to identify where learning could be identified, and quality could be improved.
• Although the provider had a complaints policy, we found this had not been followed.
• The manager had already identified that improvement was required in relation to the management of complaints. Following the inspection, a new system was put in place to ensure all feedback about the service was recorded. The manager also had further plans to ensure complaints were acted on and learning could be taken from these to improve the service.

We recommend the provider monitors the new complaints process to ensure concerns and complaints are satisfactorily resolved for all people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Not all people receive support from domiciliary care agencies with their social needs. We did not receive any feedback from people, relatives or staff about how people were supported with their social needs. We additionally did not see any information in people's care plans about this. We were therefore unable to make a judgement about this.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

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

- The provider had failed to operate effective governance systems. This meant significant concerns were identified with the quality and safety of the service. This has been further detailed in the Safe, Effective, Caring and Responsive domains of the report. When we shared these concerns with the provider they were unaware of them because they lacked a systematic approach to oversight leadership and governance. It required us to ask the provider to take action to investigate concerns.
- There was not a quality assurance process in place to monitor and drive improvement regarding areas such as recruitment processes, staffing, accidents and incidents or safeguarding concerns. We found concerns in all of these areas.
- Where audits were in place, these did not identify the concerns we did during our inspection or drive the necessary improvement. For example, medicine audits had been carried out for some people, but they either did not identify the concerns that we did and if they had, action had not been taken to drive sufficient improvement.
- Records were not accurate and risk management plans lacked important information to support staff to provide safe care. This meant people were at increased risk of harm.
- The provider failed to understand the legal framework of consent which meant people were at risk of their rights not being followed or respected.
- Incidents and complaints did not prompt learning to improve care.
- A registered manager had not been in place since September 2020. The provider had employed managers in the meantime, but these had not proved successful in becoming registered with the CQC. The nominated individual felt the management changes had impacted negatively on the quality and safety of care people received and was a significant reason for the shortfalls we identified. At the time of our inspection, a manager who had been in post for approximately three weeks told us they intended to register with CQC and provide some stability for the service.
- At our last inspection a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 was identified. This was because the provider had not always notified CQC of incidents they were required to do so by law. During this inspection, we highlighted a notifiable incident to the provider. At the time of writing this report, we have not received a notification about his. This demonstrates a lack of understanding of regulatory requirements.

The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit, we requested and received information which showed some action was being taken to begin making improvements. We also told the Local Authority of our concerns and Havant & Petersfield agreed to accept from support from them to make the necessary improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:
• Improvements were needed to ensure people consistently received empowering, high-quality care and good outcomes. These have been reported in the safe, effective, caring and responsive domains of the report.
• People and relatives provided us with a mixed view regarding how well-led the service was. Some people were happy with the management of the service. For example, one person told us, "They (staff) do a good job and are led by good people I would say." However, other people did not think the service was well run. One person told us, "The management is hopeless, and they need to up their ideas" and another said, "They (management) are all talk and promise the earth and then can't deliver and are nothing but trouble."
• The nominated individual told us they had been through a difficult time since the last inspection due to changes in the management team and with COVID-19. They felt this had contributed to some of the issues identified during the inspection. However, they felt the service was becoming more stable again and there was a good culture in the service. Staff told us the team worked well together.
• The nominated individual, the manager and the care manager demonstrated commitment to the service and expressed a wish for people to receive good, high quality care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others
People in leadership roles did not always promote the delivery of high quality person centred care.
• People and relatives did not always feel the service involved them or engaged with them effectively. In the main this related to a lack of communication with office staff. Comments included, "I can't talk to the office as they just shut me down", "I don't get anywhere with the office when I call" And, "If I want to complain I would just call the office, but they never phone me back."
• Following the inspection, the nominated individual told us they had implemented a new system in the office so they could monitor people's calls and ensure people felt listened to.
• There were no records that demonstrated people, or their relatives had been involved in decisions about the running of the service. However, the care manager had recently implemented telephone reviews where people and their relatives were asked for feedback about their care. We reviewed these records and saw positive feedback had been provided. As people's feedback using this system did not always correspond with the feedback, we received we concluded this system needed more time to be fully embedded to ensure all people's views were captured.
• Although staff had not been asked to formally feedback on the service, the care manager had consulted with staff through meetings and the supervision process and staff told us they felt listened to by the manager and the care manager. Staff said they could make suggestions, raise concerns and felt confident these would be addressed.
• Staff felt well supported by the nominated individual, manager and care manager. Comments included,"[Care manager] is amazing.", [Care manager] has been out every weekend to support the staff. [Nominated individual] has also helped at points. They are really good."
• As described in the effective section of the report, the service did not always work well with health and social professionals to support people to have good outcomes.

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

• There had been no incidents that fit the remit of the Duty of Candour regulation, so we were unable to assess their compliance with this regulation. A duty of candour incident is where an unintended or unexpected incident occurs that result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident. The provider had a policy in place, and this was understood by the manager.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure service users received person centred care.

The enforcement action we took:
We imposed conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to adhere to the Mental Capacity Act 2005.

The enforcement action we took:
We imposed conditions on the provider

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure the safe management of medicines. The failure to effectively assess, monitor and mitigate risks.

The enforcement action we took:
We imposed conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to safeguard people from the risk of abuse.

The enforcement action we took:
We imposed conditions on the providers registration.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure fit and proper persons were employed.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff were sufficiently deployed.

The enforcement action we took:

We imposed conditions on the providers registration.