Pinnacle Brit Care Ltd

Pinnacle Brit

Inspection report

01 Meadlake Place
Thorpe Lea Road
Egham
TW20 8HE

Tel: 02080048866
Website: www.pinnaclebrit.co.uk

Date of inspection visit:
12 November 2021

Date of publication:
22 March 2022

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
Pinnacle Brit provides personal care and support to older people and people with disabilities living in their own homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. At the time of our inspection all 40 people supported by the service received personal care.

People's experience of using this service and what we found
People's medicines were not being managed in a safe way which put people at risk. Staff were not trained or assessed as safe to administer medicines to people. Accidents and incidents were not always reported, and actions were not always taken to reduce reoccurrence of them.

Good infection control was not always being followed and assessments of the risks associated with people were not always assessed. The provider had not ensured that there was sufficient organisation of the staff rotas and we found that staff were at times late for calls and did not always stay for the duration of the call.

The provider and staff were not following procedures that related to safeguarding people from the risk of abuse or neglect. The recruitment of staff was not robust which put people at risk. Staff were not sufficiently trained or supervised to ensure that they were competent to carry out their role. There was a lack of understanding of the Mental Capacity Act and its principles. Where people's capacity to make specific decisions was in doubt there was no assessments undertaken by the provider.

Prior to people receiving care there was a lack of assessment of their needs. People's care was not provided in a consistent way. Care plans lacked detail and guidance for staff and information about people's backgrounds, interests and things that were important to them. Where people were being cared for at the end of their lives there was no care planning in place around this.

Where people and relatives complained about their care, this was not recorded, and insufficient actions were taking place to address their complaints. There were no systems in place to assess the quality of the care being provided. Notifications that are required to be sent to the CQC were not always being done.

There were people and relatives that told us that they felt safe with staff and there were some relatives that felt staff developed good relationships with their loved ones. Staff fed back they felt supported by the leadership.

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 24 December 2020) and there were three breaches of regulation. We only looked at the Safe, Responsive and Well-Led domains at this inspection as we had concerns around these areas. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we looked at all of the domains and we found improvements had not been made and the provider remained in breach of regulations and further regulations had been breached.

Why we inspected
The inspection was prompted in part due to concerns received about the care and support people received and the way the service was managed. We decided to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive, and Well-Led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pinnacle Brit 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 risks related to lack of robust systems in place to ensure staff arrived at the call and stayed for the duration, safe care being provided to people, and lack of detailed care planning. Breaches were also in relation to staff training and supervision of staff, a lack of understanding of the Mental Capacity Act (MCA) and the lack of robust provider and management quality assurance at this inspection

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
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 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 of their 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 in six months and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Pinnacle Brit

Detailed findings

Background to this inspection

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

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

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

The service had a manager registered with the Care Quality Commission who was also the provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed the provider to inform people and seek their consent to be contacted and we wanted the provider to be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report.

During the inspection
We called and spoke with two people who used the service about their experience of the care provided and spoke with eight relatives. At the office we spoke with six members of staff including the provider (who was also the registered manager), field care supervisor and care staff.

We reviewed a range of records including five people's care plans, daily care notes, staff rotas, multiple medication records, safeguarding records and complaints. We reviewed a variety of records relating to the management of the service including three staff recruitment files and audits of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies.

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

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

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

- Risks to people were not appropriately assessed and measures were not always in place to ensure that people were cared for safely. This was a concern identified at the previous inspection and we found this had not improved.
- One person was a risk of deteriorating mental health. We saw daily notes in their care plan detailing the person had expressed their emotional concerns. There was no assessment of risk around this in their care plan or strategies for staff on how best to support the person.
- People's nutritional and hydration risks were not always managed safely. One person was at risk of malnutrition and had a cognitive impairment. According to their care plan, staff were required to observe what the person had eaten as at times the person forgot to eat. However, there was no food and fluid chart placed in the person's home and staff were recording they had left the meal with the person. The relative fed back to us they were also concerned about this as they were not sure how much their family member was eating.
- People's care plans did not always have sufficient information for staff to reduce the risks associated with their care. We were told one person smoked. There was no risk assessment in their care plan around this other than the person being asked not to smoke when carers were present.
- Another person, according to the care plan, was at risk of falls. There was no risk assessment in relation to this or guidance for staff on how to reduce this risk despite it being recorded the person had experienced three falls. A third person had epilepsy and the field care supervisor told us the person was known to have seizures. Despite this there was no risk assessment in relation to this or guidance for staff on what they needed to do if the person had a seizure. A relative told us in relation to their family members seizures, "If there was an emergency there is nothing to show the ambulance as it is not written down [in the care plan]."
- Staff were not always aware of the risks associated with people's care and assumed the information would be in the care plans. One told us, "They [risk assessments] are in the care plans. I haven't read them."
- Accidents and incidents were not always reported or recorded which placed people at risk. There were insufficient processes in place for staff to report an accident or an incident in a person's home. The provider made us aware of two incidents where staff had to wait for an ambulance at a person's home as the person had been unwell. Neither of these incidents had been written up on an incident form.

● Another incident was identified from the service safeguarding folder where in August 2021 a person's foot had been run over by a wheelchair. The provider told us this incident form was still in the person's home and, "It will be coming back to the office shortly." This meant that appropriate actions had not been taken yet to fully investigate the incident. We could not see any actions had been taken to prevent this from happening again.
●A member of staff told us on another occasion they had witnessed an incident. They said, "A client went unresponsive and called 999 and they came almost immediately." They told us they recorded this in the daily notes but did not complete an incident form. Although there was a record that a paramedic was called no incident form was completed by the member of staff and no information on what actions were taken to prevent reoccurrence. The provider and staff were not following the service policy that stated that all incidents needed to be written up on an incident form.

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

Using medicines safely; Preventing and controlling Infection
● There was a risk people were not receiving their medicines when required. One person had recently started to use the service. The care information provided by the local authority stated, "[Person] requires medication to be administered." However, there was inconsistency from staff who were either recording on the daily notes they had administered or prompted the person's medicines. The field care supervisor was unclear as to whether the person required prompting or their medicine being administered.
● The same person had no Medicine Administration Record (MAR) written up despite requiring their medicines to be administered. The service policy stated, 'At the assessment of needs stage, information must be sought and recorded in order that the level of support required is properly indicated and that a risk assessment is completed.' We found this was not always taking place.
● Where people required time critical medicine there was no information on the MAR relating to this. The care supervisor told us there was one person with Parkinsons who they told us required their medicine to be administered four times a day at the same time. The person's care plan stated that, 'Carers must record each time they help with medication' and not that the medicine needed to be given at the same time each visit. Despite the service policy stating, 'Staff are aware of the importance of giving these medications at specific times.'
● Where people required 'as and when' medicine there was no guidance for staff on when this needed to be offered to the person.
● There was no evidence that staff had been competency assessed to ensure that they had the skills required to administer medicines. This was despite the service policy stating, 'Care workers should only administer medication when they have been assessed as competent to carry out the task after appropriate training.'
● When we arrived at the service, we were not asked for evidence of a negative COVID-19 test or asked whether we felt unwell. We also identified there was no formal system in place to ensure staff delivering care had undertaken the required weekly PCR (polymerase chain reaction). One care supervisor told us they had not taken a PCR test that week, yet they were required to go and deliver care at short notice where there was staff absence.

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

Staffing and recruitment

● Staff were not deployed effectively to ensure that people received the appropriate care. The provider told us travel time was allocated to staff, so they had sufficient time to arrive at their next call. However, when we reviewed the staff rotas, we found travel time had not been included. At times staff rotas had overlapping call times.

● There was lack of organisation by the provider to ensure staff stayed for the full length of time. Staff were required to log into the service online system using a handheld device when they arrived at a call and when they left. We reviewed the records of this and found staff were frequently not staying for the full length of their call.

● One person had been allocated a 30-minute morning and 30-minute lunch call. On 5 November 2021 staff stayed 19 minutes for the morning call and seven minutes for the lunch call. Staff had recorded they had provided care on those occasions. One person told us, "They usually stay shorter than the time they are booked for." Another said, "Some [care staff] appear to want to do as little as possible, they rush off as soon as they are finished."

● Staff were not always arriving at calls at the required time which was impacting on people's care. For example, a person fed back to us that on one day the care staff had arrived at the call to provide a meal. They said a carer then arrived at their home two hours later to provide their next meal. One person told us, "Sometimes they turn up earlier than I like, they are due at 9.00am but today they came at 8.15am." A relative said, "Once they came too early to put her [their loved one] to bed, they are sometimes too early or too late." Another told us, "If they come late, they miss a visit out."

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

● After the last inspection the provider sent us an action plan that stated, 'We will make our recruitment more robust such that no new member will be allowed to commence work until their references are fully returned and all recruitment checklists completed.' We found this was not taking place.

● The provider had not operated effective and safe recruitment practices. Three of the recruitment files we checked for staff had no full employment history with one only going back to 2017. One of these files had only one reference. This was despite the service recruitment policy stating that two references were required and a full employment history. There were other documents present in the recruitment files including DBS checks and evidence of identity.

● The provider told us 50% of their staff were agency staff. We asked for evidence recruitment checks had been undertaken for these staff. However, the provider told us they did not hold any information for these staff. The provider told us, "We don't ordinarily ask for profiles as I've used the company for a long time and I just let them know I need someone, and they send someone." This meant they could not assure themselves that appropriate background checks had been undertaken.

As robust recruitment procedures were not in place this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The people we spoke with said they felt safe with staff. One told us, "I think it [having care] makes me feel safe and secure." One relative told us, "She is safe with them, we have regular girls, so they know her and what she needs."

● However, despite this we found people were not protected from the risk of neglect. We had identified where staff were not staying for the full length of the call. One relative fed back to us they identified staff had

turned up to a call and had not checked on their family member who was in the bedroom upstairs. They said staff left the call without checking on the family member which was observed on CCTV they had installed in the home. We have reported this to the local authority.

● Although most staff received safeguarding training, staff lacked an understanding of who they needed to report their concerns to outside of the service. One member of staff told us, "I would call police or emergency services if needed."

● From the training records provided two of the 12 staff had not received safeguarding training. There was no record of when or if the providers, care supervisors or agency staff had received training. One member of staff was unable to tell us where they would access the whistleblowing policy if they needed to report a concern.

● The local authority fed back to us, prior to the inspection, that investigations into alleged abuse were lengthy due to the delay from the provider in getting information to assist with them with their enquiries.

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

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.

This is the first inspection for this domain since they were registered. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People and relatives told us an assessment of their needs was not always undertaken before the care package started. One relative said, "They did it with the hospital, they didn't discuss it with me. When I rang them, they told me what hours they were down to do."
- Prior to people using the service, we found that there was a lack of detailed assessments taking place to ensure that the service was able to meet their needs. The care supervisor told us, "The contract is from the hospital which comes with details of their needs. By the time we get there we identified more needs." We asked to look at the pre-assessments for two people that had recently started receiving care who had both been discharged from hospital. The care supervisor told us they had not yet undertaken an assessment of their needs. They told us they had left the local authority assessment in the person's home for staff to review but had not retained a copy in the office. We asked how they would formulate a care plan without this, and they showed us handwritten notes for one of the people. They said, "I know it's hard to believe but some is from memory."
- The provider told us, "If they come from hospital, we deal with the assessment within 48 hours. We can't send a carer without knowing people's needs." However, we found this was not the case and we identified that two people were receiving care without there being a care plan in place. This was despite the service policy stating a thorough assessment needs to be undertaken. A member of staff told us, "We have had occasions where a person has been sent home [from hospital] with a catheter and the office has not been told."
- Staff confirmed with us there were not always care plans in place when they visit a new client for the first time. One told us, "I think it would be helpful to have care plans." Another told us, "I find when a client first gets allocated to us for the first call or two you go in a bit blindfolded with not a lot of information." This meant that there was a risk staff may not provide the most appropriate care as they did not have full information around people's needs

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

- After the inspection the provider sent us evidence of contact they had made with health care professionals

when they had a concern about a person's health.

Staff support: induction, training, skills and experience

● People and relatives fed back they did not always feel staff were adequately trained. One relative said, "They say they are trained. Sometimes I don't think they are trained enough." Another said, "I am not sure what they know about her illness."

● People were not always supported by staff that had undergone a thorough induction programme to give them the skills to care for people effectively. According to the training records staff were required to complete 34 areas of online training over a four-day period. There was no evidence in place to test staff understanding around each of these areas. We also found that staff we spoke with were not all listed on the training matrix. Another member of staff we spoke with was on the training matrix, however it stated they had not had any of the required training.

● Staff had not had training around all of the needs of people using the service. There were people with Parkinson's and people that had catheters however, according to the matrix, training had not been provided around either of these areas.

● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. Before staff delivered care to people for the first time there was no robust systems in place to ensure they were all assessed as competent to fulfil their role. We reviewed the spot checks undertaken for all staff this year. We found only three substantive staff out of 14 listed on the matrix had received a spot check.

● The care supervisor told us they may have undertaken more spot checks but that, "Some might be in my car, but I don't keep a spreadsheet of them." We gave them the opportunity to get any remaining evidence of spot checks for staff, but these have not been provided. The provider had no systems in place to have oversight of which staff had received a spot check.

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

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

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

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

● Where people's capacity was in doubt there was no evidence that MCA capacity assessments or best interest decisions had taken place in relation to consent to care. For example, we were told by the provider that one person lacked capacity to make decisions. However, there was no capacity assessment in place or any evidence of a best interest discussion. In another person's care plan, it stated the person had concerns with memory loss and that the GP was going to undertake an assessment of this. We also noted the person had refused care on occasion. No steps had been taken by the provider to assess the person's capacity.

● The service policy stated, 'MCA Code of Practice will be followed where someone lacks capacity or where there are fluctuating needs identified and decision recorded in the care plan.' However, we found this was not taking place. This meant people may be receiving care they have not consented to.
● We saw from the training matrix that not all staff had received training around MCA. Staff we spoke with did not all have a good understanding of the principles of MCA. One told us, "This client may not be able to support me to learn about them if they do not have capacity."

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

● Relatives fed back that staff asked their family for consent before delivering care. One told us, "They always ask before they do anything." Another told us, "[Staff are] good in asking if it is ok to provide care."

Supporting people to eat and drink enough to maintain a balanced diet
● Care plans were not always detailed around what support people needed with their nutrition and hydration. For example, one care plan stated the person was completely dependent on staff preparing their meals. There was no information on the person's preferences with food and drink. We fed this back to the care supervisor who told us they would ensure more information was added.
● However, people we spoke with told us staff supported them with meal preparations. One person told us, "They make sure I get my breakfast, but I am more able to get my own now." One relative told us, "Sometimes they make her soup or a sandwich, if she changes her mind from what I have made her they will do it."
● Staff ensured that people were provided with sufficient drinks between calls. One relative told us, "They encourage her to drink more and put a bottle of water by her bed." Another said, "They make sure she has bottles of water and a cup with a straw and they make her a cup of tea."

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

This is the first inspection for this domain since they were registered. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care;

- People did not always benefit from staff who had time to get to know them. One person told us, "Some chat, some don't get to know you." A relative said, "I think they talk to her only if she talks to them."
- Records showed staff often did not stay for the full length of the call and there was a risk people who may only have social interaction from the care staff were isolated. One relative said, "They are literally just in and out, they don't listen to her, they do what they have to do and leave." Other comments included, "Could be improved on the caring side, sometimes they rush when he is eating his food and once that caused him to have a panic attack as he doesn't like being rushed" and "They sometimes leave after they have done all the care tasks she needs."
- People were not always involved in their care planning. One relative fed back they asked for only female carers but often still have a male carer attend.
- There was no evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. Care plans contained little information around how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference of a male or female carer.
- There were relatives however who fed back that individual staff involved loved ones in decisions about their care. Comments included, "We have regular girls who ask what she likes." And, "They have taken an interest in him as a person."
- Some individual care staff were well meaning and kind towards people. Comments from people and relatives on this included, "I have got to know them; I think of them as friends", "Very kind people, they have got to know what she likes, we have chat and a laugh with them" and "They are lovely and kind, we are happy with them."

Respecting and promoting people's privacy, dignity and independence

- People and relatives fed back that some staff were respectful. Comments included, "They make sure (care is undertaken) in private", "They always shut the bedroom door, it is very private" and "They always knock on the door and won't come in until she says it is ok." A member of staff told us, "We are going into their home, so we have to respect their personal needs and preferences."
- People were supported with their independence where appropriate. Comments included, "They have equipment to help her get around, but she can use the commode and although her legs aren't strong, she can walk a few steps" and "They know he is independent, he can't do a lot but he knows what he wants, he likes to be clean, and they ask him what he wants."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection of the service, we found the provider had not ensured that care plans were detailed around the needs of people. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 9.

- People and relatives did not always have sight of a care plan as most care plans were electronic. One relative said, "We don't have a file at home, they put things on their phone." Another said, "I need a care plan and full knowledge of what care they can actually provide."
- Care plans were not personalised and did not always have detailed guidance for staff specific to each person's needs. For example, there were people who had diabetes. There was no information in the care plans around the signs to look out for should the person become unwell.
- There was an "About Me" section in people's care plans however, they were sparsely completed. In the care plans we looked at there was just details of the person's date of birth, their GP and next of kin. There was no life history included or details of hobbies and interests the person had. One member of staff told us, "When a person has a family member, they will tell you everything. When people don't there is very little information." This was despite the providers action plan from the previous inspection stating this would be put in place.
- People were not always supported with their end of life care planning. We were aware there were people using the service that were near the end of their life. There was no information in their care plans on discussions with them and their relatives on their wants and wishes. One relative said, "I am not sure how close she is to end of life. I am not sure they know what she needs."
- There were no care notes written in the person's home so that people and their relatives could review. One relative said, "Staff don't record in people's care plans so relatives won't always know when staff have been." Other comments included, "They don't fill anything in." and, "The carers don't record anything; I haven't seen it" and, "I can't check if they are doing anything wrong."

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.

- There was a lack of detail in care plans around how people were able to communicate. One care plan stated the person was hard of hearing. The care plan stated, 'Please make sure you are close to me when talking to me.' However, the guidance was not clear if staff needed to be faced in front of the person or

whether the person could hear better when spoken to on one side.

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

Improving care quality in response to complaints or concerns

● There were mixed responses from people and relatives about whether they felt confident in making a complaint. Comments included, "I don't want to complain, there is always a reason they are late.", "I just phone and send an email and then they come around and talk about it." And, "If I make a complaint, I don't get a follow up to check if we were happy."

● People's complaints were not recorded, investigated or responded to that ensured improvements in the care delivery. The provider told us they had not had any complaints. However, during feedback from relatives we were made aware of complaints that had been made including staff conduct and the lateness of staff.

● Staff also fed back to us they were aware of complaints that had been made. One told us, "Sometimes a client will get very upset if they get a carer they don't like. The client said, 'I told them last time I didn't want this carer again' they became very distressed." Another staff member told us, "I asked for me to be taken off (the call). He (the relative) made a complaint about me to Pinnacle about one month ago. He said I don't take care of his wife properly." However, we checked the complaints folder and found that people and their relative's complaints were not recorded and there were no records of how many complaints had been received.

● The service complaints policy stated, 'Details of all verbal and written complaints must be recorded in the complaints book, the service user's file and in the home records.' We found the provider was not working to their own policy.

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

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 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

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

● Systems in place to monitor the delivery of care were not robust and this impacted on the care that people received. The provider told us staff used an electronic portal to sign in to calls when they arrived and when they left the person's home. The provider told us they used this system to ensure staff turned up for calls and they stayed for the duration of the call. However, there was no robust oversight of this. We identified from records staff were regularly not staying for the full length of the call.
● The provider told us if staff were running late or had missed a call they would be alerted by the online system. However, staff we spoke with told us they would move their rostered calls around to do calls that were more local to each other but without notifying the office of this. This demonstrated the provider was not checking calls were taking place on time.
● We asked the provider about this who told us, "We will be looking in to recruiting more people [staff] to have as their main responsibility oversight of the rotas and ensuring calls are planned in a safe way." However, they had not taken steps to address this prior to our inspection.
● The provider was not open and transparent with us about ensuring staff had travel time between calls. The provider told us they factored in travel time for staff in between calls. They said, "Yes they do, they are all drivers. We do the rotas, so they are travelling in the same area. 5-6 minutes." However, once they had provided us with the rotas for staff in the afternoon, they told us they were already aware the rotas had not included travel time.
● There were insufficient systems in place to robustly audit the care and make improvements where concerns had been identified. We asked to see any audits of the quality of care being provided. The provider told us they had a spreadsheet of audits, but they were unable to access them due to technical difficulties they were having. We have still not been provided with these audits.
● The service was not following their own policy that related to reviewing the quality of care. The policy stated, "Will ensure that there is effective governance, including assurance and auditing systems and processes. These will assess, monitor and drive improvement in the quality and safety of the services

provided, including the quality of the experience for Clients." We found this was not taking place.
● People and relatives fed back concerns about the leadership of the service. Comments included, "I don't know what the management is like. I don't know how they are set up it isn't clear to me" and "I haven't had a lot of dealing with the management. He [provider] rang to give me his number, he didn't follow up on how my mum was doing."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives fed back they were not formerly asked for any feedback in relation to their care. We asked the provider for the last survey they had completed for the service. They told us, "We don't have the last set of surveys/feedback as we have down-sized the office, so they have been archived." We asked if they had any action plans from these surveys and they told us they would "try to find it." We have not been provided with this.
● After the inspection we were provided with four feedback questionnaires from people. Comments about staff conduct was positive however concerns had been raised about staff not always staying for the full length of the call, did not always complete all of the care tasks and did not always arrive on time. There was no evidence to show how this had been addressed and we continued to find these shortfalls on the day of the inspection.
● Although staff fed back positively about the leadership, however they were not given an opportunity to feedback where improvements could be made to the service. The minutes of staff meetings included reminding staff about annual leave, time keeping, GDPR and infection control. However, there was no notes of staff being asked for any feedback where they felt improvements could be made.

As systems or processes were not established and operated effectively to ensure compliance with the requirements this is a repeated breach of regulation 17 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; Working in partnership with others
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Prior to this inspection we were notified by the Local Authority safeguarding team of incidents that occurred at the service including allegations of abuse and neglect. These had not been notified to us. Whilst on the inspection we identified further allegations of abuse. The provider told us they believed these did not need to be notified until the local authority had concluded their investigations. However, it is a legal requirement for the provider to notify the CQC of abuse or allegation of abuse
● The provider told us they believed these did not need to be notified until the local authority had concluded their investigations. However, as stated this is a legal requirement which was also detailed in the service policy that stated, 'A Statutory Notification is sent to CQC concerning any abuse or alleged abuse involving a person(s) using our service.' This demonstrated a lack of understanding of the regulations in relation to notifying safeguarding concerns.
● It was not clear from speaking with relatives and reviewing records the provider understood their responsibility around duty of candour. Relatives told us they were not always made aware of the outcome of investigations into concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the requirement of MCA and consent to care and treatment was being followed

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of notifiable incidents

The enforcement action we took:

We issued a fixed penalty notice

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was provided in a way that met people's individual and most current needs.

The enforcement action we took:

We have imposed conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks associated with people's care was undertaken in a safe way.

The enforcement action we took:

We have 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 provider had failed to ensure people were always protected from the risk of abuse and neglect

The enforcement action we took:

We have imposed conditions on the providers registration

Regulated activity	Regulation

Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure systems or processes were established and operated effectively to ensure compliance with the requirements

The enforcement action we took:

We have imposed conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints and concerns were investigated and appropriate action taken

The enforcement action we took:

We have imposed conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure robust recruitment procedures were in place

The enforcement action we took:

We have imposed conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff

The enforcement action we took:

We have imposed conditions on the providers registration