Pegail Ltd

# Pegail Ltd

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service:
Pegail Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, including people living with dementia, and younger disabled 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.

The service was supporting nine people with personal care at the time of the inspection. During the inspection process, the service voluntarily ceased operations and went into insolvency (the provider was unable to pay the money they owed) and people receiving care from Pegail Ltd were supported to start receiving care from other care providers. While the service stopped providing a service during the inspection process, the provider has not applied to remove the location from their CQC registration.

People's experience of using this service and what we found:
The service was not safe. On the 31 July 2019, a number of staff members went on strike and later left the company. This placed people at risk as the provider was unable to cover care calls and had to receive support from the local authority. Staff members were also deployed from the provider's care service in Essex. However, this meant that people had been receiving care from staff members who were unfamiliar with their needs.

The provider was not open and honest with people, relatives and healthcare professionals about the difficulties they were facing with staffing. People and their relatives fed-back that they found it difficult to get hold of the provider or office staff. Health care professionals also raised concerns around lack of communication from the provider. Where people experienced missed or late calls, the provider had failed to follow the Duty of Candour principles (principles requiring providers to act in an open and honest way) and people experienced poor provision of care.

Staff had not been recruited safely. People had been receiving care from staff members without appropriate checks in place or from staff members who had positive convictions. The management of risk was inadequate, and people had been receiving care from an unreliable service. People told us how staff members often rushed them, ran late and didn't stay for the allocated time.

People and their relatives told us of their worries that staff would not turn up for the next care call and people confirmed that they would not recommend the service. The management of medicines was not safe, and the provider was unable to demonstrate that people received their medicines as prescribed.

The scheduling of care calls was poor and staff members did not receive travelling time between care calls. People did not receive a weekly rota advising them of who would be arriving and at what time to deliver their care. People and their relatives told us that care staff often arrived with no ID badge and without

wearing a uniform. People received care from unfamiliar staff and this made them feel uncomfortable within their own home.

The provider was unable to demonstrate that staff had received adequate training to meet the needs of people. People and their relatives raised concerns around the competency and skill set of staff members.

It was difficult to establish whether the provider had a governance framework in place. Several documents such as complaints and incident and accidents could not be reviewed during the first day of the inspection. These were subsequently requested from the provider but were not provided before the service ceased operations.

People were not consistently supported to have maximum choice and control of their lives as they were unsure of when care staff would be arriving, and this limited their ability to live their daily life.

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

Rating at last inspection:
The last rating for this service was Requires Improvement (report published 16 April 2019) and the provider was found to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. 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 found improvements had not been made and the provider remained in breach of regulations.

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

Enforcement:
We have identified breaches in relation to Regulation 9 (Person Centred Care), Regulation 10 (Dignity and Respect), Regulation 12 (Safe Care and Treatment), Regulation 17 (Good Governance), Regulation 18 (Staffing), Regulation 19 (Fit and Proper Persons Employed), Regulation 20 (Duty of Candour) and Regulation 18 Registration Regulations 2009 (Notifications of other incidents).

Full information about the Care Quality Commission's (CQC) regulatory response to more serious concerns found in inspections and appeals is added to reports after any representation and appeals have been concluded.

Follow up:
The service voluntarily stopped operating during the inspection process as the provider went into insolvency. However, the provider has not applied to remove the location from their registration. We will continue to monitor information we receive about the service. 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.

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| **Is the service safe?**<br>The service was not Safe.<br>Details are in our Safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not Effective.<br>Details are in our Effective findings below | **Inadequate** |
| **Is the service caring?**<br>The service was not Caring.<br>Details are in our Caring findings below. | **Inadequate** |
| **Is the service responsive?**<br>The service was not Responsive.<br>Details are in our Responsive findings below. | **Inadequate** |
| **Is the service well-led?**<br>The service was not Well-Led.<br>Details are in our Well-Led findings below. | **Inadequate** |

# Pegail Ltd

**Detailed findings**

## Background to this inspection

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

Inspection team:
This inspection was carried out by two inspectors and one 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.

Service and service type:
Pegail Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, including people living with dementia, and younger disabled adults. The service was supporting nine people with personal care at the time of the inspection.

Not everyone using Pegail Ltd receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

Notice of inspection:
We gave the service three days' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 21 August 2019 and ended on 26 August 2019. We visited the office location on 21 August 2019 and were informed on the 28 August 2019 that the service had voluntarily closed and the provider was going into insolvency. From the 29 August 2019, people who had been receiving care from

Pegail Ltd started receiving care from other care providers.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection in March 2019. We sought feedback from the local authority who worked 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 used all of this information to plan our inspection.

During the inspection:
We spoke with the provider via Skype as they were out of the country at the time of the inspection. The acting manager who was overseeing the provider's Essex branch attended the inspection and we spoke with them. We spoke with five people who used the service and three relatives via telephone. We gained feedback from three staff members via telephone.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two healthcare professionals to gain their feedback. We also asked for immediate assurances to mitigate some of the risks identified following the first day of the inspection. Some immediate assurances were provided and then the service became dormant as they ceased providing a service.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection in March 2019 this key question was rated as Requires Improvement. This was because safe recruitment practice had not always been followed. For example, references from previous employers had not always been received by the provider before staff began working. At this inspection this key question deteriorated to Inadequate. Improvements to staff recruitment practice had not taken place and people were not safe and were at risk of avoidable harm.

Staffing and recruitment:

- People were at risk of serious harm due to a failure to ensure staff were recruited safely and in line with regulatory requirements. During our inspection visit we reviewed recruitment files for several staff and found that DBS checks (Disclosure and Barring Service) were not in place for all staff files. The recruitment files for four staff members failed to contain evidence of a valid disclosure and barring service check.
- Where staff members had either disclosed a positive conviction or their DBS check referred to a positive conviction, risk assessments were not in place to assess whether the staff member was safe to work with adults at risk in the community. For example, one staff member who worked between May and June 2019 had a positive conviction for theft and deception. The care call rota between 26 May and 11 June 2019 demonstrated that this staff member often attended care calls alone.
- Pre-employment checks were not fully completed. Staff recruitment files demonstrates that four staff members attended care calls before the submission of their application form. This meant that the provider had not completed pre-employment checks before staff were deemed competent and of good character to safely support people. For example, one staff member who was shadowing care calls and supporting people had a positive conviction in place and no references from previous employers had been obtained. A risk assessment was not in place for the conviction and the provider was unable to demonstrate how safe recruitment practice had been followed for this staff member.
- At the last inspection in March 2019, safe recruitment practice was not followed as the provider had not always obtained references from previous employers before staff began working. At this inspection, improvements had not been made. One staff member who was attending care calls had no references on file. Two staff members who worked in June 2019 had no references on file. One staff member started work in November 2018, however a reference request was not made until March 2019. Whilst one reference request was made, the reference was not returned. The provider was unable to demonstrate that the staff member was of good character.
- The care rota between May 2019 and August 2019 demonstrated that a further six staff members had been scheduled to attend care calls. The recruitment files for these six staff members were not available for review. These staff files were requested from the provider but not supplied before the service closed.
- During the inspection process, the acting manager took immediate action to ensure that staff without a current criminal records check were restricted from providing care to people.

The provider did not have robust recruitment processes in place. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were being placed at risk of unavoidable harm due to insufficient staffing levels and poor scheduling of care calls. On the 31 July 2019, a number of staff went on strike due to pay disputes and consequently walked out. To ensure continuity of care, the provider deployed staff from their Essex branch to assist with covering care calls and sought support from the local authority. However, between 31 July and 21 August 2019, people reported missed calls and poor provision of care. One person told us, "Two weeks ago they missed a couple of calls, the late-night ones."
● The scheduling of care calls was poor and staff members were not consistently given travel time. For example, the care rota for one staff member on 5 August 2019 demonstrated that they were meant to start their first care call at 06.45am to 07.30am with the next care call due to start at 07.05am. The overlap of calls meant staff were unable to meet people's needs and consequently ran late to care calls. The care rotas between 1 July and 21 August 2019 included numerous examples of poor scheduling with no travel time. One staff member told us, "The rotas are not good, there's no travel time and the calls aren't at the right times. I end up travelling for about five hours a day that I don't get paid for. It's not ideal for the clients, if we could follow a rota that was right, we could do it, but if you follow what we have now you'd finish at midnight, travel for hours and then not get paid."
● Feedback from people and their relatives was poor and people advised that staff members often ran late and did not stay the allocated time. One person told us, "They're supposed to come at 08.00am to 08.30am to do the breakfast and sometimes they don't come until 10.30am. They're supposed to come at tea time at 16.00pm to 16.30pm and they don't come till 18.00pm and then at 20.30pm, but sometimes they come until 21.30pm. The problem is that they've got too much to do, they've got all these patients and no staff. There used to be a good staff team, but there was a big argument over money and the staff all walked out. That was three weeks ago. They've got these new staff from Essex. They've only got one of the old team left. I don't know how they can carry on like that; I don't want a wash and breakfast at 11.00am in the morning."
● The provider had introduced an electronic system to monitor people's care visits. However, we found this system was not robust and had not been working effectively for several months. Staff were required to log in and out at every call and this enabled the provider to monitor in real time whether staff were arriving on time, if any calls were missed or if staff were not staying the allocated times. Since 31 July 2019, staff had not been using the system, therefore the provider had no oversight as to whether staff were arriving on time, if any calls were missed or that staff were staying the allocated time. One person told us, "They're always in a hurry. I'm supposed to have an hour in the morning, I'm bedridden. I can't do things for myself. They always seem to want to get going and get on with the rest of their calls." A relative told us, "It's supposed to be 45 minutes in the morning, but it's about 20 really. Lunch is half an hour, but that's usually 10-15 minutes and at night time it's supposed to be 45 minutes to get ready for bed. But that's just a waste of money, they just say to put their pyjamas on and leave. They do nothing.  And some of them don't talk to him at all. They just chivvy or bully him. In the morning they say 'Get up [name], you've got to get up, I'll be late for my next call'. I think really? They could try to just talk to him, he cooperates when you do that."
● The provider was unable to demonstrate effective oversight of the monitoring of care calls to ensure people received a safe service that met their needs.

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
● The provider was unable to demonstrate that all staff members had received safeguarding adults training. One member of staff told us that they received online training when they first joined the company and spoke about the potential signs of abuse. However, where staff had received safeguarding training, the provider had not ensured that systems were in place and followed to ensure safeguarding concerns were reported to the local authority safeguarding team and CQC as required.

● One relative raised concerns regarding an incident whereby money was stolen from their loved one. This incident had been reported to management. However, a safeguarding concern was not raised, and the incident was not notified to the CQC and it was unclear if the police were notified of this incident. The staff member was no longer working for Pegail Ltd. However, the person's relative raised concerns that action was not taken to ensure a similar incident would not happen to another vulnerable person. Further information on this incident could not be discussed with the provider as the service ceased operating during the inspection process.
● Further information on the failure to notify CQC is detailed within the 'Well-Led' section of the report.

Assessing risk, safety monitoring and management: Using Medicines Safely:
● Medicines management was not always safe. The provider could not demonstrate that people were given their medicines as prescribed.
● People's Medication Administration Records (MAR charts) were not consistently completed to demonstrate that people received their medicines as prescribed. For example, one person was prescribed eye drops to be administered during their evening call. Their MAR chart for the month of July 2019 reflected that these eye drops had not been administered on 14 occasions. They were also prescribed a medicine for blood pressure to be administered during their morning call. The MAR chart reflected that this medicine was not administered on 18 occasions. The provider had failed to identify if this was a recording error only or whether staff failed to administer the person's medicines at these care calls. We found this was a consistent theme.
● We brought these concerns to the attention of the acting manager who advised that moving forward, MAR charts and daily notes would be audited on a weekly basis to monitor and ensure that people are receiving their medicines when required. However, the service stopped providing care to people during the inspection process.
● Where people were administered time sensitive medicines, the scheduling of care calls did not allow for these medicines to be administered in such a way. One person told us, "No. They're always late. I've got to be honest, haven't I? It's supposed to be between 08.00am to 08.30am in the morning and they don't come until 10.00am or 10.30am. I know they're busy and short staffed but it's not good enough. I take a lot of medication and I'm supposed to take some of them every four hours. One of them I'm supposed to take in the morning, that's supposed to be when I wake up, not at 11.00am in the morning. Sometimes there's a tablet missing, and I have to say about it. It's a good job I've got a good brain and I know what medication I take, and I notice if there's one or two of them missing."
● Some people took medicine only when required (PRN) such as paracetamol. There were no protocols in place to provide staff with information about this medicine. For example, when it was to be offered and how often it could be taken.
● The provider was unable to demonstrate that staff's competency to safely administer medicines had been assessed. Some people received their medicine via a PEG (percutaneous endoscopic gastrostomy tube). The provider was also unable to demonstrate that staff's ability to safely administer medicines via a PEG had been assessed and staff had been deemed as competent. Information on staff competency was requested from the provider following the first day of the inspection. However, this information was not provided before the service stopped operating.

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

● Care plans considered risks associated with the environment and whether the person smoked, however, where people had risks associated with their healthcare needs, robust risk assessments were not consistently in place.

● Care and support was provided to people living with catheters to drain urine from the bladder. One person's care plan identified that their catheter could by-pass and therefore urine would not drain effectively. The person's daily notes also referred to an issue with the catheter blocking on the 16 August 2019. Whilst the care plan identified an associated risk, a risk assessment was not in place. Guidance was therefore not available on the signs of a bypassing catheter, the steps to take, alongside how to safely care for a catheter and how to spot and minimise the risk of catheter acquired infections. Long standing members of staff were aware of the associated risks and how to manage them. One staff member told us, "We make sure the area is clean and the urine is flowing. If the catheter is blocked, we contact the district nurses." However, the lack of guidance meant that for new care staff or staff deployed from the Essex branch information was not readily available.

● Some people required support to safely manage their PEG. Information was available within people's care plans that they required support to advance and rotate the PEG weekly. However, risk assessments were not in place on how to mitigate the risk of infection alongside the signs of infection. One relative told us, "Our regular care worker knows how to safely care for the PEG, but they are leaving and with the other care workers, they are hit and miss. They don't all know how to care for the PEG and this worries me."

● Guidance produced by the Health and Safety Executive advised that individual person centred moving and handling risk assessments should be in place. These should consider the assistance needed for different types of transfer and the specific equipment required. Care plans considered the equipment needed and where people required a hoist this was documented. However, information on the sling required, the attachment of the sling were missing. Therefore, for new members of staff and staff deployed from the Essex branch, information on how to safely support someone to move and transfer with a hoist, was not readily available.

Failure to maintain accurate records and assess, monitor and mitigate the risks relating to people's care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:

●Staff had access to appropriate equipment such as gloves to use the prevent the risk of spreading and infection. This was confirmed by people and their relatives.

Learning lessons when things go wrong:

●The provider had no formal process for reviewing and reflecting on incidents to avoid similar issues occurring in the future. Without a clear process for analysing and reviewing information there was a high probability that repeated incidents would go undetected and result in significant harm to people

Inadequate

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Inadequate. 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:
● The delivery of care and care planning was not consistently in line with best practice guidance. For example, the provider was not following best practice guidelines as advised by the National Institute for Health and Care Excellence. Staff did not have access to guidance on the use of 'as required' medicines and what the medicine was for. Information was not in place on the minimum time between doses and the maximum dose alongside how staff should monitor for the effectiveness of the medicine.
● Prior to receiving care from Pegail Ltd, most people received an assessment to ensure the service could meet their care needs. This assessment then formulated the care plan. However, one person had been receiving a package of care from Pegail Ltd for three weeks and a care plan had not yet been formulated. Staff supporting this person did not have access to guidance on how to safely and effectively provide care.

Staff support: induction, training, skills and experience:
● The provider was unable to demonstrate that all staff employed had received the appropriate training and induction to ensure people received effective care. Some staff files included evidence of online training and a couple of staff members told us about their online training. However, the dates for the training completed was before staff had started working for Pegail Ltd.
● The provider was unable to demonstrate that where staff were new to care, they completed an induction based on the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Whilst some staff members told us they received online training and shadowed a couple of care calls prior to working alone, the provider was unable to demonstrate that staff were competent and skilled to provide the level of care required.
● Care and support was provided to people living with catheters and PEGs in place. The provider was unable to demonstrate that staff had received training specific to these needs and that staff competency had been assessed. This posed a risk that people were at risk of receiving poor care due to lack of staff skill and training. Information on staff training and competency was requested from the provider during the inspection process. However, this information was not provided and the service subsequently ceased operations during the inspection process.
● People and their relatives raised concerns regarding the competency of staff members. One relative told us, "They need more training." One person told us, "Catheter care could be better. Some do it and some don't. Not all of them are trained. I think the training should be compulsory. They say, 'you'll have to wait.' Another person told us, "Before they were a good team, they were nice girls. Now we're getting any Tom, Dick or Harry. They don't know me, but the others did."

● Staff members told us that they felt communication from head office could be improved but that they felt able to raise concerns.

The provider's failure to ensure that staff received an appropriate induction and provide ongoing learning and development for staff placed people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet:
● Information was available in people's care plans on the level of support required with eating and drinking. One person's care plan identified that they required support from staff members to prepare meals and drinks at each care call.
● Staff members told us about the support they provided to people to ensure their nutritional and hydration needs were met. However, feedback from people was not consistently positive. One relative told us, "I leave a flan and I expect they'll give him some of that with some potatoes and salad or something. But no, they give him the whole thing, that's a family sized flan. They've got no idea about nutrition. He complains that when they make him a sandwich, they don't butter the bread."
● Daily notes were recorded on an electronic system which staff members accessed on their phone. However, the electronic system did not consistently work and therefore daily notes were not consistently maintained. Therefore, information was not always recorded at each care call on whether the person received support with their nutrition and hydration needs. For example, one person's care plan identified that they required support at each care call to ensure their nutritional needs were met. The provider's electronic system demonstrated that no daily note entries had been made since 15th August 2019. The provider was unable to demonstrate that care had been provided which met the person's needs.
● We have detailed in the 'Well-Led' domain the risks associated with poor documentation.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
● Staff members told us how they worked in partnership with healthcare professionals. One staff member told us, "We regularly contact the district nurses if a person's catheter is blocked or bypassing."
● People's care plans, daily notes and MAR charts were electronic which staff members accessed on their mobile phones. This meant that in the event of an emergency and the paramedics being called, emergency staff were not able to review people's MAR charts to see when they last received their medicines. One relative raised concerns about this and commented, "When (Person) had a fall and the paramedics attended they advised that they were unable to administer any pain relief as they were unable to see when (person) last had some."

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's care plans included information on consent and people had signed their care plan providing their consent for care and support to be delivered in line with their care plan.
● Staff members understood the importance of gaining people's consent. One staff member told us, "I always explain what I'm doing to ensure people understand and that they have provided consent for me to support them."

Inadequate

# Is the service caring?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People and their relatives told us they were let down by the provider and staff. People confirmed that staff failed to treat them with dignity and respect. One relative told us, "No, to be honest. She needs to live her life like a normal person. There's no dignity if she's out with her friends and she has to leave them at 19.30pm to go home so she be put to bed at 20.30pm."
- Feedback from people demonstrated that staff were not always compassionate. One person told us, "Some of them haven't any experience of care. Some walked out during a shift, they couldn't cope with the work and some have a bad attitude. One of the staff had a bad attitude towards incontinence. I was in a bit of a mess and they said I should have cleaned myself up. I've got a catheter and pads. I can't help it if the bag slipped. They weren't pleased."
- People's requests for female or male staff members was not consistently respected. One person told us, "No. Yesterday [man's name] came, I hadn't seen him before. I said, 'No disrespect to you, but I don't want you washing me'. I don't want a young man looking at my body and washing my bits. I said I don't want that, it's on my plan." We reviewed this person's care plan and identified that it stated their request for female only care workers. However, the scheduling of care calls meant this wish and request was not respected. During a two-week period at the beginning of August 2019, male care workers were sent to over seventy percent of this person's care calls.
- People and their relatives told us that care calls were often cut short and staff members arrived late to care calls. One person told us, "There always in a rush. There not brilliant, I am unhappy with them."
- Due to a recent staff strike, people were not receiving care from a consistent staff team and staff from the Essex branch had been deployed. However, people confirmed that staff did not consistently wear uniform or ID badges. One relative told us, "No they don't. I would prefer them to wear a uniform because then she would know they are from the company." Another person told us, "Rarely, if ever [wear a uniform]. I think sometimes they should, it would give them a bit of authority." People were not consistently respected by staff as staff failed to clearly identify themselves to people as employees of Pegail Ltd.

Failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The unreliability of the service and lack of communication meant people did not always feel supported or cared for. People and their relatives told us about their worries and fears that care workers would not turn up. One relative told us, "No, I can't guarantee they'll come."

● The provider utilised a communication chat group through an instant messaging application. This was a forum for all staff members to share information. However, people's personal sensitive information had been shared through this forum and the provider who was also part of this chat group failed to recognise that this was a potential breach of GDPR (General Data Protection Regulation).

Supporting people to express their views and be involved in making decisions about their care:
● The provider told us that regular telephone calls were held with people to review their package of care and gain their feedback on how the care was going. During the inspection process, the provider was unable to demonstrate evidence of these telephone calls and reviews. Information was requested from the provider, but the provider did not respond to our requests for information before the service ceased operations.
● People and their relatives told us of their frustration with the company and concerns around poor communication. People and healthcare professionals told us of their troubles about getting hold of office staff. One relative commented, "It's absolutely dreadful trying to talk to management." A healthcare professional told us, "Getting hold of office staff is difficult. When I do get hold of someone, I don't know who I'm talking to and whether they work at the Brighton branch or Essex branch." Another person told us, "No, I tried to get in touch with them at 15.00pm in the afternoon and I couldn't. I had to go through Care Link. It isn't very good." People felt the lack of communication and unreliable service was having a negative impact on their lives.

Inadequate

# 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 deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The provider had systematically failed to ensure personalised care was planned to ensure people were given choice and control to meet their needs. People's care plans contained personalised information. Information was available on the life history of the person and what was important to the person. Care plans also included information on the timings of the care calls and the tasks required to be completed at each care call. However, the provision and quality of care delivered was not person centred. People received an unreliable service which did not enhance their quality of life.
- The delivery of care was not person centred as people received care calls not in line with their agreed care plan. For example, one person's care plan identified that there morning call should be between 07.00am to 07.30am. However, the scheduling rota demonstrated that this person's morning call was usually scheduled for 09.00am. Daily notes reflected that staff often arrived at times that were not in line with people's care plans or the scheduling rota. People could not be confident that staff would arrive on time or as specified in their care plan.
- People were not consistently aware of their care plan and where people had care plans in place, people and their relatives felt staff did not follow it. One relative told us, "No. They don't write anything down, it's all on their phones. If he doesn't eat his lunch, they don't record it." Another person told us, "Yes. But I don't know if they look at it, because it says no men and they keep sending men. They say, 'Well, you know we can't help it, we've got no one else."
- People received care from an inconsistent service. People were unaware of who would be providing their care and at what time. People had experienced missed calls with no apology and people fed-back that often staff did not stay the allocated time and often rushed them.

People did not receive person-centred care that met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs:
Since 2016 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 included information on people's communication methods. However, where a communication need was identified, action was not taken to ensure information was provided in an accessible way. For example, one person was registered blind. There was no information on how the person's care plan was provided in an accessible format.

● People and their relatives felt communication from the provider and office staff was poor.

Improving care quality in response to complaints or concerns:
● Information on the provider's complaint policy and number of complaints received since the last inspection in March 2019 was requested from the provider. However, this information was not provided, and the service subsequently stopped operating during the inspection process.
● People and their relatives had mixed opinions about the complaints process. One person told us that they had made a couple of complaints and they were dealt with. Whereas one relative raised concerns around making a complaint due to fear of resentment. Another relative told us that they complain everyday with no effect.

End of life care and support:
● The provider was not providing support to people at the end of their life at the time of inspection. There was no evidence within care records that the provider had spoken with people and their relatives about their preferences and wishes in relation to advance plans and wishes for when people reached the end of their lives.

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 in March 2019 this key question was rated as Requires Improvement. This was because the provider had not notified us about all safeguarding incidents. At this inspection this key question deteriorated to Inadequate. The provider had failed to ensure that all notifiable events were reported to the CQC. We also found widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had failed to create an empowering, open and person-centred culture. People were not consistently receiving a reliable service which meant good outcomes for people were not being achieved.
- Staff and people fed-back that the organisation of the company was poor. One staff member told us, "This company at first was really good, it used to be run well and we were happy. It used to run like clockwork. Then the manager left, and it went downhill."
- Systems and processes were not in place to encourage continuous learning and improve care. The provider used an electronic monitoring system. However, this system had not been used effectively since the last inspection in April 2019. Staff told us about problems accessing the system when supporting people in their own homes. This meant staff weren't always able to log in and out at care calls or complete daily records or MAR charts. Despite this ongoing shortfall, the provider had failed to learn from these problems or implement changes to ensure the ongoing monitoring of care calls.
- The daily notes for two people had not been recorded since 15th August 2019 despite one person's care plan stating that they required double up care, four times a day. One person had started their package of care on the 13th August 2019 which consisted of three care calls a day. Only one daily note on the 13th August 2019 had been recorded. The absence of daily notes and MAR charts meant the provider could not be assured that care was taking place and that the care delivered was in line with the care plan. We found that this was a consistent theme across people's daily notes.
- People were dissatisfied with the provision of care and expressed their frustration with the staff and company. One person told us, "They should be looking at recruitment, that's very poor and at their attitude." Another person told us, "The mind-set should be changed, they should think how you would do it if it was your relative. They should be better at assessing basic needs." One relative commented, "It's really a failing service."

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

- Quality monitoring systems were not effective to ensure people received safe care.
- The day to day management of Pegail Ltd had been delegated to a care coordinator. The provider was unable to demonstrate how they maintained oversight of the running of the service. Copies of audits and action plans were requested during the inspection process but were not provided before the service

stopped operating.
● The provider failed to implement systems and processes to drive improvement. Shortfalls in documentation had not been identified. For example, MAR charts had recording gaps and daily notes were not consistently maintained.
● The provider was unable to demonstrate their ability to monitor missed and late calls to be able to identify patterns and protect people from potential neglect.
● Information on incidents and accidents could not be reviewed on the day of the inspection. Further information was requested from the provider on how incidents and accidents were reviewed to identify themes and patterns. This information was not provided before the stopped operating.

Failure to operate a robust governance framework was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●At the last inspection in March 2019, the provider was not consistently notifying CQC of significant events, such as safeguarding incidents. At this inspection, improvements had not been made. In July 2019, an incident was reported to the police. The provider failed to notify us of this incident. Feedback from a healthcare professional demonstrated that a safeguarding concern had been raised in August 2019 following a person experiencing missed care calls which resulted in their re-admittance to hospital. The provider had not notified CQC of this safeguarding concern.

The provider had not ensured that we were notified of all safeguarding and other notifiable incidents. This was a continued breach of Regulation 18 Notification of Other Incidents of the Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:
● The provider was not open and honest with people, relatives and healthcare professionals. In July 2019, a number of staff went on strike and subsequently left the company. This had a direct impact of the quality and provision of care. The provider was unable to cover all care calls and had to seek support from the local authority. Following this, the provider's contract with the local authority was suspended due to missed care calls, late care calls and poor communication.
● People were not consistently informed or provided updates from the provider regarding what was happening and where people had experienced missed calls, the provider failed to act in line with the Duty of Candour regulation. This is a regulation which requires providers to send written apologies and be open and honest about any shortfalls in the provision of care. One person told us, "There's been no formal communication from the office. That amazes me. They should have communicated with the clients and with Adult Social Care if they had difficulty in meeting their commitments. There's been no communication. They should have spoken to their clients and said we're having these problems, but we're doing this and that to resolve them and if you need to speak to someone, call this number. There's been no one to discuss it with, it's all been hearsay from the carers who have had gripes about the pay and the training. I would have thought they would have sent out an announcement letter to reassure people. There's been none of that. I think it's pretty poor."
● The provider started a package of care following their contract being suspended. We asked the provider if the person was aware of their contract being suspended and whether their social worker had been informed. The provider informed us that they had informed the person's social worker but was unable to evidence this. We sought feedback from the person and their social worker who advised us that they had not been informed of the company's suspension or the staffing concerns.

Failure to be open and honest with people was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others:

● There was no evidence that people had been supported to express their views about the care and support they received. People also expressed their concerns and frustration about lack of communication from the provider and company. People and their relatives confirmed that they would not recommend the service. One relative told us, "No. I feel bad saying that, the staff are doing their jobs, but it's the management."

● Information on staff meetings and surveys was requested during the inspection process but not provided before the service stopped operating.

● Feedback from healthcare professionals was not consistently positive. One healthcare professional raised concerns around the lack of communication from the provider along with concerns around being unable to get hold of office staff.

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<br><br>The care and treatment of service users was not appropriate, did not meet their needs and did not reflect their preferences. Regulation 9 (1) (a) (b) (c). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Service users were not treated with dignity and respect. Regulation 10 (1). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems or processes were not established or operated effectively. Regulation 17 (1) (2) (a) (b) (c). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Fit and proper persons were not employed. Regulation 19 (1) (a). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>The registered provider had not acted in an open and transparent way with the relevant persons in relation to care and treatment provided to service users. Regulation 20 (1) (2) (a) (b) (3) (a) (b) (c) (d) (e). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent skilled and experienced staff were not deployed. Regulation 18 (1) (2) (a). |

**The enforcement action we took:**

We served a Notice of Proposal to vary the provider's registration condition so that they could no longer operate from Pegail Ltd Brighton and Hove.