Parkins Care Angels Limited

Unit 4, Bentinck Court

Inspection report

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15 February 2018

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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This focused inspection took place on 15 February 2018. We gave the provider 48 hours' notice of our visit as the service provides care to people living in their own homes and we needed to make sure the provider would be available to assist with the inspection.

We carried out an announced comprehensive inspection of this service on 27 and 31 August 2017 when we found three breaches of legal requirements regarding staff recruitment, risk management and the way the provider monitored quality in the service and made improvements. After the comprehensive inspection, the provider sent us an action plan dated 26 September 2017 to say what they would do to meet legal requirements in relation to the breaches.

We undertook this announced focused inspection on 15 February 2018 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. We inspected the service against two of the five questions we ask about services: is the service Safe and Well-Led?

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Unit 4 Bentinck Court on our website at www.cqc.org.uk.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Unit 4 Bentinck Court is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people and younger adults with a physical or learning disability. At the time of this inspection the service was supporting 73 people. The registered manager left the service in December 2017 and the provider appointed a new manager who had applied for registration with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not everyone using Unit 4 Bentinck Court receives a 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 receive this support we also take into account any wider social care provided.

We found the provider had taken action to address the concerns we had following our last inspection. However, they did not always notify the Care Quality Commission of significant events and incidents affecting people using the service. This was a breach of Regulation 18 of the Care Quality Commission

(Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

The provider had taken action to ensure their assessments of risks to people using the service were up to date and regularly reviewed. They carried out checks on new care workers to make sure they were suitable to work with people using the service.

The provider had systems in place to protect people from abuse and care workers completed safeguarding training.

People using the service received the medicines they needed safely and the provider had systems to prevent and control infections.

The provider had improved the ways they monitored quality in the service and identified areas that needed improvement.

The provider had appointed a manager and they had applied to the Care Quality Commission for registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had taken action to ensure their assessments of risks to people using the service were up to date and regularly reviewed.

The provider carried out checks on new care workers to make sure they were suitable to work with people using the service.

The provider had systems in place to protect people from abuse and care workers completed safeguarding training.

People using the service received the medicines they needed safely and the provider had systems to prevent and control infections.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

The provider did not always notify the Care Quality Commission of significant events and incidents affecting people using the service.

The provider had improved the ways they monitored quality in the service and identified areas that needed improvement.

The provider had appointed a manager and they had applied to the Care Quality Commission for registration.

Unit 4, Bentinck Court

Detailed findings

Background to this inspection

This focused inspection took place on 15 February 2018. We gave the provider 48 hours' notice of our visit as the service provides care to people living in their own homes and we needed to make sure the provider would be available to assist with the inspection.

We undertook this announced focused inspection on 15 February 2018 to check that the provider had followed their plan they had sent us after our comprehensive inspection of 27 and 31 August 2017 and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. We inspected the service against two of the five questions we ask about services: is the service Safe and Well-Led?

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

One inspector carried out the inspection. Before the inspection we reviewed the information we held about the provider and the location. This included the report of the last comprehensive inspection and the provider's action plan dated 26 September 2017.

We visited the service's office on 15 February 2018 to meet with one of the provider's directors and the manager. We reviewed progress they had made to address the issues we raised following our last inspection and checked a number of records, policies, procedures and audits the provider carried out. We looked at the care records and risk assessments for five people using the service, staff records for four care workers and other records related to the running of the service.

Good

Is the service safe?

Our findings

At our last comprehensive inspection of the service in August 2017 we found people may have been at risk of receiving unsafe or inappropriate care as the provider did not review and update assessments of possible risks. At the inspection in February 2018 we found that the provider had taken action and made sure they assessed and reviewed risks to people using the service before they started to support them. People's care records included assessments of possible risks and guidance for care workers on how to mitigate these risks. For example, each care record included an assessment of potential risks in the person's home environment and we saw the manager updated these when they reviewed the person's care plan.

People's records also included an assessment of infection control risks and we saw care workers had access to personal protective equipment including disposable gloves, aprons, shoe covers and hand gel. The provider also completed moving and handling risk assessments and gave care workers guidance and training on the use of equipment people used in their homes. For example, when one person's mobility needs increased, the manager reviewed the risk assessment and ensured their care workers were familiar with the equipment the person used.

All of the risk assessments we saw were up to date and had been reviewed by the manager when they visited people to complete a care plan review. The manager was also able to show us they had a programme of reviews arranged to ensure that people's care plans and risk assessments included current information for care workers about the person's care and support needs.

At the inspection in August 2017 we also found the provider did not complete checks on new care workers before they started to support people using the service. At the inspection in February 2018 the staff records we checked showed that the provider completed checks before they appointed new care workers to care for and support people using the service. The manager and provider had audited staff files and obtained references where these were missing. They had also produced a recruitment pack for applicants that clearly stated the provider would make no decision about employment until they had received references and completed other checks. All of the staff files we checked included proof of the person's identity and right to work in the UK, an employment history, references from previous employers or people known to the applicant and a Disclosure and Barring Service check.

The provider had systems and processes in place to safeguard people from abuse. We saw they had a policy and procedures for safeguarding people using the service and they had reviewed and updated this in January 2018. The procedure included definitions of possible kinds of abuse and contact details for the local authority's safeguarding adults team. Staff records we reviewed included evidence that care workers had completed safeguarding training and this reassured us they would know what appropriate actions to take if they had concerns about a person using the service.

Where people using the service needed support with their prescribed medicines, the provider had systems in place to support them. They had a policy and procedures they had reviewed and updated to include 2017 guidance from the National Institute for Health and Care Excellence (NICE) on managing medicines for

adults receiving social care in the community. The care records we reviewed showed that, where people needed support with their medicines, their care workers provided this and recorded the support they provided.

The provider learnt lessons and took action to make improvements when things went wrong. For example, during the inspection we discussed with a director of the provider, Parkins Care Angels Limited and the manager the need to notify the Care Quality Commission (CQC) of significant events and incidents that affected people using the service, as required by law. Following the inspection the manager told us, "Reading up on the CQC website I have a better understanding of the reporting process and documentation. It is vital to follow the process of reporting, recording and documenting actual and factual facts, not just in relation to deaths but medication incidents that occur and have an impact on the health and welfare of the client, safeguarding issues investigation and reporting of suspected or actual abuse."

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection in August 2017 we found that the provider did not operate effective quality monitoring systems to identify where they needed to make improvements. We issued a warning notice and gave the provider two months to address the concerns we had identified. At the inspection in February 2017 we found the provider had taken action and improved the audits and checks they carried out to identify areas for improvement.

Since they started work in the service in January 2018 the manager had audited people's care plans and risk assessments and staff recruitment records. We saw they had ensured all required information was available in recruitment records for care workers, people's care plans were up to date and included current information for their care workers about their care and support needs. Care workers' work schedules also included a summary of the main care needs and tasks they needed to complete on each visit to each client.

The manager had also reviewed the provider's training programme to ensure each care worker completed refresher training when this was due. The provider told us the audits would be carried out regularly in future and this reassured us they had taken action to monitor quality in the service and identify areas where improvements were needed.

The manager told us, "I have learnt that if complaints are dealt with properly and in a timely manner and clients' relatives, carers and advocates are taken seriously, issues can be resolved and straight forward but ensuring that they are informed throughout by phone or letter or the personal touch by a visit from representative of the Company or Manager. All written complaints are acknowledged within 5 working days, all complaints are investigated within 14 days of being made and all complaints are responded to in writing within 28 days. This encourages good relationships between both parties by communicating to improve our services and clients feel confident they can raise concerns anytime. Again documenting and reporting all complaints and allegations and keeping all and the appropriate authorities informed."

However, the provider did not always notify the Care Quality Commission (CQC) of significant events and incidents that affected people using the service. For example, we saw evidence that a person using the service had died. The provider had notified the local authority of the death but they had failed to notify CQC, as required by law.

We discussed this with the manager and one of the directors of the provider, Parkins Care Angels Limited. The manager told us they had not previously managed a domiciliary care provider and they were not aware of the regulation. The director also said they were not aware of the regulation and they believed they only had to notify the local authority.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider and manager carried out checks on care workers when they were with clients to monitor the care and support people received and they also asked people using the service for their views on their care.

We saw records of eight spot checks on care workers the manager had carried out in February 2018.

Since our last inspection in August 2017 the provider's registered manager had left the service. The provider appointed a new manager and they started work in the service in January 2018. We saw evidence they had also applied to the CQC for registration in January 2018.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did not always notify the Care Quality Commission of incidents that affect the health, safety and welfare of people who use services.