Profectus Healthcare Ltd

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 7 and 8 April 2016. After that inspection, in October 2016 we received concerns in relation to the conduct of the registered manager who is also the provider and general concerns about staffing in relation to recruitment practices and staff skills and knowledge.

As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Profectus Healthcare Ltd on our website at www.cqc.org.uk.

This announced focused inspection took place on the 15 October 2016. At the time of this inspection Profectus Healthcare was providing care to four people in their own homes for a range of personal and nursing care needs. We carried out this inspection because we had received information of concern in relation to staffing and allegations about the provider of the service.

People were supported by staff who had not been subject to safe recruitment practices to make sure they were of a suitable character to provide care to people. The provider had failed to ensure that staff were subject to appropriate pre-employment checks. Staff without criminal records checks and pre-employment references were providing care to people in their own homes unsupervised.

People could not be assured that they would be protected from the risk of harm. The provider had failed to implement an appropriate safeguarding procedure. We found examples of people that had experienced missed calls that the provider was aware of, that had not been reported to the appropriate external authorities.

There had been a failure in the leadership, governance and oversight of the service. The provider had failed to implement their own policies and procedures and ensure that safe systems of working were followed. The provider was unable to maintain a strategic oversight of the service because they were delivering people's care and support personally due to staff shortages.

We received serious allegations about the registered manager, who was also the sole provider, clinical lead and director of Profectus Healthcare. The allegations are subject to an on-going investigation by the Local Authority Safeguarding Adults Team.

The provider had failed to ensure that an appropriate staffing structure was implemented to coordinate people's care and support safely. There were insufficient numbers of suitably competent staff employed by the provider to ensure that people received the care that Profectus healthcare had been commissioned to provide.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Quality Commission (CQC) 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.

At this focussed inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Staff had not been recruited safely and staff without appropriate pre-employment checks were providing care to people in their own homes unsupervised.

Appropriate safeguarding procedures had not been implemented to protect people from the risk of harm.

The provider did not have any staff available that had been recruited safely to deploy to provide people's care.

The provider had failed to implement an appropriate staffing structure in order to coordinate people's care and support safely.

Profectus Healthcare Ltd

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Profectus Healthcare on 15 October 2016. This inspection was carried out in response to information of concern that had been received in relation to the provider and staffing arrangements of Profectus Healthcare.

The inspection was undertaken by two inspectors. During this inspection we met with the registered manager who was also the provider of the service. We looked at the recruitment records relating to all of the care staff that were currently being deployed by Profectus Healthcare Ltd.

We reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners that help place and monitor the care of people being supported by the provider that have information about the quality of the service.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we had received serious allegations about the registered manager of the service who was also the provider and sole director. The nature of these allegations were of such significance that we took urgent action to suspend the registration of the registered manager whilst a safeguarding investigation into these allegations takes place.

People were exposed to the risk of harm because appropriate checks and references had not been obtained for staff that were providing care and support to people in their own homes without supervision. We reviewed nine staff files and found that there was no evidence that any member of staff currently being deployed by Profectus Healthcare had current Disclosure Barring Service (DBS) Checks completed. These are police checks which identify if prospective staff have had a criminal record or were barred from working with children and adults.

The staff file for one person who was scheduled to provide personal care to people could not be located in the office. The provider told us that they did not know where this file was and that they were in the process of scanning all staff files so that they were stored electronically. There was no evidence that the staff actively providing care to people had been subject to DBS checks prior to providing care and support and the provider could not provide assurances that all staff had been subject to these checks.

Staff files had no evidence of DBS checks completed by Profectus Healthcare and one staff file had a copy of a DBS check completed by another organisation that showed that the member of staff had a criminal conviction. The provider had not completed any form of risk assessment or recorded any form of discussion about the relevance of this offence to the work being undertaken with vulnerable people using the service in their own home. The provider told us that they had been unaware that this person had a criminal conviction. We found numerous examples of staff without DBS checks providing care and support to people in their own homes unsupervised and the provider had not considered the risks to people that this posed. The provider had not consistently obtained references from people's previous employers for new staff to assure themselves that prospective staff were of good character and had the required skills, knowledge and values to be effective in their role.

The provider told us that they were unable to access the records that showed they had obtained criminal records checks for staff however, acknowledged that some staff had been deployed without criminal records checks having been obtained. The provider told us that these staff had worked under supervision however we found that records demonstrated these staff had been deployed to provide people's care without any supervision.

This is a breach of Regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

There were not systems in place to protect people from harm or the risk of harm. The provider had not implemented an appropriate safeguarding procedure and prior to this inspection we had received concerns

that people had been placed at the risk of harm. We found examples where the provider was aware that people had experienced missed calls however, these had not been reported to the local safeguarding team. For example, we had been made aware of a missed call for one person during the week prior to our inspection; the provider told us that they were also aware of this missed call however; this had not been reported to the local safeguarding team by the provider.

This was in breach of Regulation 13 (3) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

The management and staffing infrastructure implemented by the provider was not sufficient to ensure that people consistently received safe care and support. The provider was also the registered manager, sole director and clinical lead. There were insufficient staffing resources available within the service to oversee the day to day operation and ensure that people received safe care in the absence of the provider.

The provider told us that they had been unable to provide adequate leadership and oversight of the service and this had resulted in the shortfalls that we identified during this focussed inspection. Governance procedures to assure the quality and safety of care that people received had not been implemented and due to significant staff shortages the provider had been delivering a substantial proportion of people's care and support. This had compounded the lack of appropriate systems being implemented because the provider was unable to deliver care and support to people and manage the day to day operation of the agency safely.

During this inspection the provider contacted CQC to inform us that they were unwell and therefore would be unable to provide care and support to the people that Profectus Healthcare had been commissioned to provide care for. In the absence of the provider there was no other suitable individual employed to coordinate people's care or to provide management oversight of the service. There was no other nurse employed to oversee people's nursing care needs. The provider did not work with people's service commissioners to ensure a smooth transfer of care or to ensure that people received the care that they required during the transition of care providers. We worked closely with people's service commissioners to ensure that people received the care that they required.

The provider had failed to implement an effective staffing structure to coordinate and provide people's care and support safely and consistently. The lack of suitably qualified and competent staff constituted a breach of Regulation 18 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

The provider had not followed safe recruitment practices or ensured that they had sufficient numbers of staff, recruited safely, that they were able to deploy to provide people's care and support. This meant that the provider did not have any staff available that were suitable to be deployed to provide people's care and support because they could not provide evidence that any member of staff had been recruited safely. The provider was unable to meet their commitment to provide any of the care that they had been commissioned to provide because they did not have staff available that were safe to deploy. The provider had failed to ensure that an appropriate staffing structure had been implemented to coordinate people's care and support safely. When people had been exposed to harm appropriate notifications to external agencies such as the Care Quality Commission or Local Authority Safeguarding Team had not been completed. People were exposed to the on-going risk of harm because procedures had not been implemented to report instances of omissions in people's care to the appropriate external agencies.