Purple Care TM Limited

Purple Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Purple Care is a domiciliary care agency looking after people in their own homes. At the time of the inspection the service supported 60 people with their personal care. 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.

People's experience of using this service and what we found
People were at risk of receiving poor care as the provider did not have adequate systems and processes in place to monitor the quality of the care people received. People were at risk of not being supported in a safe way as the provider did not have robust systems to assess people's risks; they did not use evidenced based tools or follow best practice guidance to assess risks and plan.

People were at risk of receiving care that was not appropriate to meet their needs as staff did not receive adequate information and guidance they required to support people. People were at risk of harm as staff did not fully understand their roles and responsibilities to safeguard people.

People did not always receive their calls on time or for the allocated amount of time. People were not supported to have their medicines in a safe way. The provider did not have an adequate system to monitor medicines management or to monitor calls.

People were at risk of not receiving care and support in their preferred way as the provider did not effectively assess their needs and choices. Staff did not have appropriate training for all areas of care they delivered. People were not always supported to eat and drink in a timely way due to late calls.

People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible . However, there was a lack of understanding of the Mental Capacity Act and people's capacity was not consistently recorded. We have made a recommendation about this.

People were supported to access healthcare services when required by caring and friendly staff who knew how to respect their privacy and dignity. People were not always involved in reviewing their care plans or in decisions about their care.

People did not always receive personalised care as care plans did not contain individualised information.

People felt that concerns raised were not always resolved adequately.

The provider did not understand their regulatory duties and responsibilities. The provider did not have adequate systems in place to assess, monitor and manage quality and safety of the service being provided to people.

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 Good (published 25 January 2018).

Why we inspected
The inspection was prompted in part due to concerns received about poor care. A decision was made for us 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 report.

Enforcement
We have identified breaches in relation to safe care, person-centred care and the management of the service 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.

Since the last inspection we recognised that the provider had failed to notify CQC of incidents and deaths. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to closely monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

Purple Care

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
The inspection team consisted of two inspectors, one inspection manager 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
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service should have had a manager registered with the Care Quality Commission. This means that they and the provider would be legally responsible for how the service is run and for the quality and safety of the care provided. However, this service did not have a registered manager at the time of the inspection.

Notice of inspection
We gave the service 48 hours' 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 12 June 2019 and ended on 20 June 2019. We visited the office location on 12 June 2019 and 18 June 2019.

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. 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.
We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and six relatives about their experience of the care provided. We spoke with nine members of staff including the provider, the care manager and care workers.

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

After the inspection
After the onsite inspection we continued to seek information from the provider to validate judgements. We looked at training data and quality assurance records. We spoke with a professional who regularly works with the service.

Requires Improvement

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People who were being supported to have their medicines were not being supported in a safe way.
- People and their relatives told us that they were not being supported to have these at the correct times. Relatives said, "There have been times when they showed up too late for [names] meds", and, "What worries me is call times, they are too early sometimes for medicines". Prescribed medication needs to be taken at evenly spaced intervals for the safety of the person and in some instances to adequately relieve pain, late or early calls meant people were not taking their medication at the correct time.
- Medication administration records did not always clearly state what medicines were being administered, leaving it open for errors. Staff said that they had spotted numerous medicines errors and had reported them to management. The management of medicines was no following best practise guidance which meant people were at risk of not receiving their medicines as prescribed.

The provider did not ensure proper and safe management of medicines. This is a breach of Regulation 12(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing and recruitment

- People and their relatives did not always feel there were enough staff to keep people safe, this was due to the lateness of the calls. A relative explained, "When I was there on Tuesday they came at 11.30am to give them breakfast and medicines which are needed before that time, along with food as they wouldn't have eaten since the night before…this is not acceptable or safe".
- Staff said that they did not have enough time to get from one call to the next. Records we reviewed showed a significant amount of late calls. Relatives also said that carers did not stay for the allotted time and left early.
- The provider did not have a clear system for calculating how many staff were required for each day and per visit.

The provider left people at risk by not ensuring staff made calls at the correct times. This is a breach of Regulation 12(2)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

- Some people had the same small team of carers supporting them on a regular basis and knew them well. For others this was not the case, one relative said, "There is always different people coming, they have not been advised on how to deal with [name] bandages, they are not knowledgeable".
- Robust pre-employment checks were being carried out on staff to make sure they were safe and suitable

to work at the service.

Systems and processes to safeguard people from the risk of abuse
● People were at significant risk of avoidable harm and neglect due to a lack of systems and processes in place.
● Staff were not all up to date with their safeguarding adults training. Staff we spoke to lacked an understanding of how to recognise abuse, safeguarding procedures and were unaware of who to report this to beyond their own management team.
● The provider did not conduct comprehensive investigations in safeguarding incidents and they were not being recorded in an organised manner.
● The provider had policies for safeguarding adults, safeguarding children and whistleblowing. However, these did not have contact information for the local authority, safeguarding team or CQC, they were generic and were not regularly reviewed, they included the details of the previous manager. The provider was not following the policy as it indicated that police incidents were notifiable to the CQC which they had not been.

The provider did not ensure people were safeguarded against potential abuse and did not have an effective policy and procedure in place. This is a breach of Regulation 12(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Assessing risk, safety monitoring and management
● People's risks were not being assessed, managed or monitored appropriately.
● People's risks were not always assessed prior to being supported by Purple Care. There were some significant delays in completing any risk assessments. For example, one person was being supported with their medicines for eight days before a risk assessment had been conducted.
● Where risk assessments had been completed these were vague, were not linked to plans of care, were not person centred and did not provide clear guidance for staff. For example, people's risk assessments for personal care were the same with only the name changed. This meant that people were at risk of not being supported in safe way or how they maybe want their care delivered.

The provider did not ensure people's risks were being assessed and managed appropriately. This is a breach of Regulation 12(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

At the time of the inspection the provider was working with the local authority to improve their risk assessment paperwork. However, those that had been completed still lacked detail and did not help to inform the care plans that were available to staff.

Learning lessons when things go wrong
● The provider did not have a robust system in place to record and analyse accident and incidents. The provider did not have a clear understanding of what counts as an incident meaning the records were incomplete, incidents were not thoroughly investigated, and no lessons learnt to prevent or reduce them happening again.

The provider did not ensure that incidents affecting people were reviewed, investigated and monitored. This is a breach of Regulation 12(2)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

● The provider could provide some examples of where lessons had been learnt. One example was around

pressure sore care and a delay in getting the person seen by a district nurse; they have now implemented a procedure to clarify that the district nurse has attended.
● The provider communicated to the staff team via a secure notification system that flagged up on their mobile phones, meaning they had access to important information in real time.

Preventing and controlling infection
● People confirmed that staff wore personal protective equipment (PPE), such as gloves, when supporting them. This meant that the risk of spreading infection was reduced.
● Not all staff had received infection control or food hygiene training. This meant that people who were supported with their meals were left at risk of poor hygiene standards which increased the risk of food poisoning.

The provider did not ensure that staff were appropriately trained to prevent the risk of infection. This is a breach of Regulation 12(2)(h) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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

- People's needs did not appear to be fully assessed and recorded prior to starting with the service, the provider was often basing care plans on the commissioner's assessments. Some people's care plans did include some information about people's needs and choices, but these were lacking in detail.
- A relative said, "[name] has a care plans from social services, but they need to be a bit more aware for her special needs."
- The provider had started to use an IT system that linked to staff phones to record information about people, however this was focussed on benefiting the service rather than people. Staff said they did receive information about people on this system, but it was minimal. Some staff had not seen people's plans of care or assessments. This meant that the system could have a negative impact on people due to staff not being aware of their full needs and risks.
- The provider was not always supporting their staff to deliver care in line with best practice due to the lack of guidance being provided to them.

The provider failed to ensure that care and treatment was designed to achieve people's preferences and ensure their needs were met. This is a breach of Regulation 9(1) (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person-centred care.

Staff support: induction, training, skills and experience

- Staff who were new to support work had an induction to the service which included basic training and shadowing of experienced staff. However, staff that had previous experience in support work did not always complete a full induction.
- Staff had access to online training and had been provided with some face to face training. However, they were not appropriately trained in all areas to meet people's needs, for example catheter care and food hygiene. The provider told us that no formal catheter care training was provided to staff by healthcare professionals and that new staff were shown what to do by those who cared for people. Some staff had received formal training in other areas of care by healthcare professionals, such as occupational therapists.
- People and their relatives didn't always feel that all staff had the skills to support them properly.

The provider failed to ensure staff providing care to service users had the qualifications, skills and experience to do so safely. This is a breach of Regulation 12(2)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

● Staff received on-going support from the provider in the form of supervisions.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported some people to eat and drink, however people and their relatives felt that due to the inconsistent times of calls and late calls they did not always have food and fluid when they required it. One relative said, "One day mum was in tears as all she wanted was food and drink and it was coming too late". Another said, "Mum needs her food on time and that's not happening."
● Plans of care and assessments contained limited information for staff to support people with eating in drinking in a safe way and did not include their likes and dislikes.
● Staff monitored people's food and fluid intake if it had been identified they were at risk of malnutrition; however, these were not being completed properly nor were there identified targets; meaning they were ineffective.

The provider was not doing all that was practicable to mitigate risks in relation to people's nutrition and hydration. This is a breach of Regulation 12(2)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

● Staff received training in mental capacity however some had a lack of understanding on the principles of the MCA.
● The service recorded in some people's records that they lacked capacity however this was not consistent and did not provide clear guidelines for staff.
● The provider attended best interest meetings but did not initiate these meetings. The provider did ensure that advocates were involved in these meetings where appropriate.

We recommend improvements are made to increase understanding and the recording around people's capacity.

● Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked with other agencies including social services, district nurses and occupational therapists.
● A healthcare professional gave positive feedback about the service and explained that they had worked together to achieve a good outcome for a person. They said, "Due to support from Purple Care [name] will soon be discharged, she was not eating before, and they keep working with [name] and it is helping [name]".

● People's plans of care did not contain clear information about people's needs and conditions, which meant in times of emergency other services may not be able to easily retrieve the information required to

assist them.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Overall people felt they were supported by staff who were caring and respectful. One person said, "Most carers are good and kind." A relative said, "Everyone seems lovely, the carers seem professional in their attitude."
- People who had been supported by the same staff for a number of years had built up good relationships with them and staff knew them well. We saw feedback from a relative which said, "[Staff] is extremely caring and totally understanding of [name] needs and fully accommodating of her wishes. [Staff] goes "the extra mile" in his care.."
- Staff spoke about people in a kind and caring way. However, due to the lack of risk assessments and care plans staff did not know how to give the care safely to meet people's physical needs. Care plans did not have the information regarding people's social, cultural and spiritual needs for them to be able to respect their preferences. Some staff had not even seen people's care plans.
- The provider told us that when they interviewed potential staff members part of the interview is about whether they would be able to meet people's diverse cultural needs. However, we saw no evidence of this being recorded in interview notes. There was an Equality, Inclusion and Diversity policy however the focus was on staff and did not mention how the service would meet the equality and diversity needs of people using the service.

Supporting people to express their views and be involved in making decisions about their care

- The service encouraged people to express their views through regular feedback reviews that were either done over the telephone or face to face with a member of the management team. However, there was no evidence that information from these reviews resulted in changes to the service they received.
- People did not have information on how to access an advocate to support their choice, independence and control of their care if they needed. An advocate is an independent person who can help support people to express their views and understand their rights.

Respecting and promoting people's privacy, dignity and independence

- Staff understood how to respect people's privacy. Staff explained, "It's just simple things, ensure that you cover people with a towel when delivering personal care and that the door is shut. Make sure you are telling them what you are doing, saying exactly what you are doing at the time. Most people have capacity, so I ask them what they would like and make sure its ok that you are supporting them."
- Staff did not always refer to people in a respectful way; daily notes which documented the care delivered to people contained undignified language.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People's care plans were very basic; they consisted of visit requirements for staff based on the assessments by people's commissioners. There was a risk that people's care was not appropriate or met their needs as people's care plans did not reflect care based on robust risk assessments.
- People's care plans did not provide staff with adequate guidelines on how to meet people's needs and preferences. Care plans did not always include people's social, cultural or spiritual needs. Care plans did not always include people's preferences for example whether they had a preferred name or whether they preferred female or male carers.
- The provider had not ensured people's needs had been regularly assessed or reviewed. Where people had provided feedback on choices and changes, care plans had not been updated to reflect these. People's care plans did not always reflect people's current needs.

The provider did not design care with a view to achieve people's preferences and ensure their needs were met. This is a breach of Regulation 9(1) & (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person-centred care.

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.

- People's care plans contained limited information on their communication needs or how they preferred to receive information.
- The provider said that at the time of the inspection no aids to support communication, such as a whiteboard, were being used. It is acknowledged that this was because there was only one person with communication needs being supported, who the service believed did not require communication aids.
- They did have a company on contract to translate documents into different languages or formats if required to meet people's needs.

Improving care quality in response to complaints or concerns

- People and their relatives said they would talk to staff or the provider if they had any concerns, however they acknowledged these were not often resolved in a timely manner. One relative said, "Management are not responsive at all, we had an incident with a male carer who comes at night, he upset [name] so we said

don't send him again, but they did! It took a couple of calls for it to sink in."
● The provider did not have a clear and up to date policy and process in place for handling complaints.

End of life care and support
● Staff explained that when they supported people at the end of their life no specific care plan had been implemented for staff to follow. This meant they were not provided with guidance on how to meet a person's wishes, choices and needs at the end of their life.
●There was limited information within people's care plans regarding end of life wishes.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were at risk of not receiving safe care. The provider did not have systems in place to make sure all risks had been assessed, monitored and mitigated.
- The provider had been made aware of people's risks from assessments carried out by commissioners, however, these did not reflect all of people's current needs. The provider failed to ensure that adequate risks assessments were carried out from which comprehensive care plans could have been developed to mitigate risks to people.
- Staff were not provided with clear guidelines on how to support people. For example, staff were supporting people with catheter care, but there were no risk assessments or care plans in place around safe catheter care or actions to take should there be any problems such as the catheter blocking.
- Staff did not have sufficient guidance or instruction on how to manage people's known risks such as diabetes, poor mobility or choking. There were no adequate risk assessments or care plans to mitigate these known risks.
- The service did not have a registered manager in post. The provider did not have a good understanding of their regulatory requirements. For example, they did not understand their legal duty to send notifications to CQC as required.
- The provider did not always ensure people's daily notes were kept securely or understand the importance of having contemporaneous records.

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

- The provider did not have adequate systems in place to make sure people received person-centred care.
- People's care plans did not reflect all of their preferences, wishes and needs.
- Staff did not have all the information they required to provide safe care.
- The provider did not have sufficient systems in place to identify when support and care was not delivered in line with best practice, which means there was a risk unsafe care would go unrecognised.

The provider failed to ensure that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided to people in their care. This placed people at risk of harm. This is a breach of Regulation 17(1)(2)(a,c)of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

The provider failed to notify CQC of deaths and incidents. The provider failed to ensure that there is a registered manager in post, this is a breach of their registration conditions.
This is a breach of Regulation 18(2) and 16 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 did discuss some incidents with people and their relatives to ensure transparency, however this was not always documented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider gathered feedback from people using the service as part of their review process. However, this was not a formal survey and no documented actions had been taken as a result.

● People and their relatives did not always feel listened to and that feedback was not always acted upon.

● Most staff said they attended regular meetings, although part time staff felt they were not included in this. Meeting minutes were not always documented. It was unclear if any action was taken on staff suggestions.

Continuous learning and improving care

● The provider was in the process of updating their audits and care plans because of feedback from the local authority.

Working in partnership with others

● The service worked in partnership with a range of health and social care professionals as well as the commissioners and local authority.

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 People may not receive care in a pesonalised way and staff did not have clear guidelines to work from.

The enforcement action we took:

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