Purple Care TM Limited

Purple Care

Inspection report

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16 September 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Purple Care is a domiciliary care service, providing personal care to people in their own homes. At the end of the inspection they were providing personal care to 67 people. Purple care is registered to provide personal care to children and adults with a physical disability, learning disability or autistic spectrum disorder; dementia and mental health needs.

People's experience of using this service and what we found
The provider had informed people, during the Covid-19 pandemic care calls would not be at a set time. This decision was not person centred and meant some people did not know when to expect their care which put them at risk of harm.

Office staff also provided personal care to people, they did not wear face masks whilst undertaking their duties in the office. This increased the risk of transmission of Covid-19. We have made a recommendation about this.

There had been no registered manager in post since June 2018, the provider was therefore responsible for the delivery of the regulated activity. A manager had been appointed but had not yet commenced their role at the time of the inspection. The locations rating of performance was not displayed at the location or on the services website.

Quality assurance systems and processes were not always effective. Audits of call times did not identify a significant variance in the delivery of some people's call times. This meant no action had been taken to improve call times.

The electronic record keeping system enabled the management team to have a 'live' oversight of care delivery and to respond to alerts such as when medicines had not been signed for, care staff were late, or care tasks had been recorded as not completed.

People were supported by staff that had been safely recruited. Staff had a good knowledge of risks associated with providing people's care, including infection control. Staff had received adequate training to meet people's individual care needs, their competency was assessed before they gave people their medicines. Staff knew how to identify, and report abuse to keep people safe. Accidents and incidents were reported and reviewed. Measures were put in place to reduce risks to people.

People were not always supported to have maximum choice and control of their lives. People's preferences and wishes regarding their care delivery were not always respected. Staff supported them in the least restrictive way possible and in their best interests.

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 (published 15 February 2020, updated 03 September 2020).

Why we inspected
We received concerns in relation to safe staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. You can see what action we have asked the provider to take at the end of this full report.

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

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 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 well-led?

Requires Improvement

The service was not always 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 was undertaken by two inspectors, an assistant inspector and an 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.

Two inspectors visited the office location. The inspection team made telephone calls to people, relatives and staff prior to visiting the office location.

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

The service did not have a manager registered with the Care Quality Commission. A manager had been appointed but had not commenced their role at the time of our inspection. This means that only the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection.

The provider requested the inspection take place a day later, to provide a safe environment for the inspection to take place and for social distancing to be maintained.

Inspection activity started on 14 September 2020. The inspection team undertook calls to people, relatives

and staff on the 14 and 15 September 2020. Two inspectors visited the office location on 16 September 2020.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people who used the service and nine relatives about their experience of the care provided. We spoke with eight members of staff including the nominated individual, deputy manager, administrator and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found and spoke with a healthcare professional.

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.

Staffing and recruitment

● During the Covid-19 pandemic the provider had extended 'call windows' for breakfast, lunch, tea and bed calls. Records showed variance in care delivery times and some people told us, they did not know when to expect their calls. One person had diabetes. Their breakfast call time varied by two hours and 17 minutes in one week during September 2020. On one day they waited just over 16 hours, between their bedtime and breakfast call. This meant their breakfast was delayed and they may become incontinent.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The rota scheduling system accounted for travel time between calls. However, staff told us travel time was not always enough in some areas. A staff member said, "It is enough time, but it does depend on the roads. If they are clear it's ok." Another staff member said, "Sometimes it gets busy if someone is caught in traffic." Following the inspection, the provider told us, at times calls may be late due to staff supporting people that are unwell, awaiting medical assistance or working alongside professionals.

● Safe recruitment checks had been undertaken to ensure people were protected from being supported by unsuitable staff. This included seeking suitable references and undertaking checks with the disclosure and barring service (DBS).

Using medicines safely

● Whilst the majority of people received their medicines on time. The variance in call times meant people may not receive their medicines at the correct time. For example, one person was prescribed medicines that needed to be given four to six hours apart. Records showed the time they received their care meant these medicines were given significantly earlier than the prescribed recommendation. This meant there was a risk of harm to the person from receiving medicines too close together.

There was a risk people may not receive their medicines at the prescribed time due to the variance in call times. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did not administer medicines until they had been assessed as competent to do so. They knew what to do if they made an error. One staff member told us, "I would report it immediately and fill in an incident report."

● The electronic record keeping system alerted office staff when a medicine had not been recorded as administered, enabling them to act and ensure medicines had been administered.
● Audits of Medicines Administration Records (MARs) were undertaken monthly. The office received alerts daily if people's medicines had not been recorded as administered. Records showed, action had been taken to ensure people had received their medicines.

Preventing and controlling infection
● The service did not always follow government guidance for use of Personal Protective Equipment (PPE). For example; office staff did not wear face masks in the office, despite some of the staff delivering personal care to people. We recommend the service review its Covid-19 risk assessments.
● Most people provided positive feedback about staff using personal protective equipment (PPE) in their homes. One person said, "Staff all come in with mask, apron and gloves on. When they leave, they take them off and put them in the bin outside."
● Staff had received infection control and Covid-19 training. They were aware of their responsibilities to respond appropriately to protect people from the spread of infection. One staff member said, "We have a duty of care to keep us safe and the people around us. When we go to people's houses, we put aprons, face masks and gloves."
● The service had adequate stock of PPE.

Assessing risk, safety monitoring and management
● Risks associated with people's care, support and environment had been identified and assessed. Some risk assessments relating to people's specific health needs, required further information so staff could identify a deterioration in their condition. We discussed this with the nominated individual. Following the inspection, they told us they had made the required changes to one person's risk assessment.
● Staff reported changes in people's needs to the management team to ensure people's risk assessments were updated. A staff member said, "If there is a rapid change, a deterioration of some kind. You need the risk assessments to be changed quite quickly."
● Staff had received training to use mobility equipment in people's homes. They had a good knowledge of people's individual risks and the support they needed.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with the care they received. A person told us, "Care is as safe as it can be." A relative said, "The care is 100% safe, they [staff] are brilliant actually."
● Staff demonstrated a comprehensive knowledge of safeguarding systems and processes. They knew the signs of abuse and knew how to report safeguarding concerns. One staff member told us, "If I witnessed abuse, I would report that immediately." Staff told us the management team would address concerns and make the required referrals to the local authority.
● Staff knew how to whistle-blow and knew how to raise concerns if they felt they were not being listened to or their concerns acted upon. One staff member told us, "There is a whistleblowing policy. If the manager doesn't deal with the concern, I will contact the CQC and local authority."

Learning lessons when things go wrong
● Staff knew how to report accidents and incidents. One staff member told us, "There is an emergency number given in induction paperwork for out of hours emergencies. If had someone had a fall, I would call the out of hours emergency line to seek advice."
● Accidents and incidents had been reviewed by the management team and action had been taken to mitigate against risks. Further Improvements were needed to identify themes and trends.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There had been no registered manager in place since June 2018. Providers are required to ensure a manager registered with the Care Quality Commission (CQC) is in place in locations where the regulated activity of personal care is carried out. A new manager had been recruited and were due to commence their role following the inspection. In the absence of a registered manager the provider was legally responsible for ensuring the service met the regulatory requirements.
- It is a legal requirement for the provider to display the CQC's rating of performance at the providers place of business and on the provider's own website. This was not displayed at either the place of business or website.
- Since the last inspection, a new electronic call monitoring system had been introduced. Whilst this had driven improvements in some areas, there continued to be inaccuracies in the data relating to specific geographical areas due to signal issues.
- Systems and processes to assess, monitor and improve the quality and safety of services were not always effective. Audits of call times were based on the time the provider had scheduled people's call for. Compliance data was inaccurate as call times varied. There was no improvement plan in place to improve call times.
- The services Covid-19 risk assessment did not account for all known risks, such as office staff delivering personal care to people in their homes.
- The service did not always keep an accurate and complete record of contact with professional's involved in people's care. For example, the provider told us they had sought advice from professionals in relation to one person's medicines. The providers records contradicted those held by one healthcare professional who informed us they had no contact with the service about this issue prior to our inspection. This meant we could not be assured the providers records were an accurate account of contact with health professionals.

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

- The Local Authority told us when a care package had been commissioned, there was an expectation for providers to identify a specific time for calls based on people's needs and preferences and to arrive within 15 minutes of the start of the call time. This had not happened as there had been some confusion in the interpretation of the contract and the provider had made changes to call times during the Covid-19 pandemic.

● We received mixed feedback about call times, whilst some people were happy with their call times, others told us their care was not always delivered at the time they needed it and they did not always know when staff would be attending. The provider told us, they were aware some people were not happy with their call times. Despite this, the service continued to take on new packages which further impacted call schedules.
● Some people told us, and records evidenced staff did not always stay for the duration of their call. The reason for leaving the call early was not always recorded.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Legally required notifications had been submitted to the CQC.
● Staff were clear about their roles and responsibilities towards the people they supported and felt listened to by the provider.
● Concerns relating to staff performance were addressed in line with the providers policies and procedures to improve the quality of care being provided
● Since the last inspection the provider had acted in response to people's concerns regarding the lack of consistent staff. Most people told us they received support from staff that knew them well. They told us staff were kind and caring.

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 management team were aware of the duty of candour, which sets out how providers should explain and apologise when things have gone wrong with people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Monthly telephone reviews were undertaken by the service to seek their views. These were reviewed by the manager. Records showed the provider had amended some call times following people's feedback, however it was not always possible to accommodate people's requests.

Working in partnership with others
● The provider was committed to supporting people to be discharged from hospital to their own home and worked with the local authority to facilitate this.

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 12 HSCA RA Regulations 2014 Safe care and treatment The timing of care calls put people at risk of avoidable harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not robust enough to demonstrate safety was effectively managed