FMP Priority Care Services Limited

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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?	**Requires Improvement**

Summary of findings

Overall summary

About the service: FMP Priority Care Services Limited is a domiciliary care agency that was providing personal care to 11 people living in their own home at the time of the inspection. This included older people and people living with a dementia or a physical disability.

People's experience of using this service: Risks to people's health were not always assessed to provide staff with the necessary guidance on how to keep people safe. Medicines were not always managed safely and quality checks had not picked up on areas where improvement was needed. The provider was not ensuring that staff had the qualifications, skills and experience to provide care safely.

New staff had not completed a full programme of training. The registered manager had an understanding of mental capacity, and people's rights around making their own decisions. However, they were not correctly recording capacity assessments or best interest decisions.

Complaints were not being correctly recorded and one relative was not happy with the way their complaint was handled.

The service's internal systems had failed to identify the issues we found on our visit. People and their relatives had not been regularly asked for feedback on the service.

Staff were kind and patient and people were involved in decisions about their care.

People received care that was personalised to them but care plans were not always up to date or accurate.

We identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care, fit and proper persons employed, complaints and governance. Details of action we have asked the provider to take can be found at the end of this report.

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

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Rating at last inspection: This was the service's first inspection since becoming registered on 30 November 2017.

Why we inspected: This inspection was a scheduled inspection carried out in line with our inspection programme timescales.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received 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 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?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

FMP Priority Care Services Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two adult social care inspectors and an expert by experience who made phone calls to people or relatives in their home. 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: FMP Priority Care Services Limited is a domiciliary care agency. It provides care to people living in their own homes.

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.

Notice of inspection: We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 25 February 2019 and ended on 26 February 2019. We visited the office location on 26 February 2019 to see the manager and to review care records and policies and procedures. Phone calls to people and their relatives were made on the 25 February 2019.

What we did: We reviewed the information we had received about the service since the last inspection. The provider had completed a Provider Information Return (PIR) on 9 May 2018. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they

plan to make. This information was used to plan our inspection and was taken into account when we made judgements in this report.

We looked at three people's care files and three staff files to review recruitment, training and supervision records. We looked at records of accidents, incidents, complaints and compliments and reviewed audits, quality assurance reports and surveys.

We spoke with the registered manager/provider and two care staff. People who used the service were unable to share their views with us over the telephone but we did speak with seven relatives over the phone.

Requires Improvement

Is the service safe?

Our findings

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

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.

Assessing risk, safety monitoring and management.
• Staff did not have information about how to minimise risks to people. We saw one person at risk of falling, but staff had not been given guidance about how this risk could be reduced.
• The provider did not have an effective system to monitor that people's visits happened as planned. There had been two missed calls reported in the ten days prior to our inspection. On both of these occasions family members had reported the missed calls. The registered manager told us that on both occasion the staff member had made a mistake after becoming mixed up about the calls they were due to attend. Staff attendance at calls was monitored using a signing in sheet in people's homes.
The registered manager told us they were looking into an electronic monitoring system that would alert them to missed calls but this had not yet been actioned.
• The provider was not following recognised guidelines such as NICE which states 'Missed home care visits can have serious implications for an older person's health and wellbeing and providers should make it a priority to avoid them'

The provider had not taken all practical steps to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

Staffing and recruitment.
• Safe recruitment processes had not always been followed. Two staff had only one reference on file, one staff member had no DBS check (criminal record and lists of any people barred from working with vulnerable people) recorded and another had unexplained gaps in their employment history.
• Relatives said there were sufficient staff in place to cover all calls, including those calls where two staff were required. One relative told us, "My relative has a double-up call and they always send two staff."

The provider had not taken steps to ensure effective recruitment and selection procedures were in place. This was a breach of regulation 19 of the Health and Social Care Act 200 (Regulated Activities) - Fit and proper persons employed.

Using medicines safely.
• We were unable to check if people received their medicines as prescribed as records were not well completed. Gaps where staff had not signed to say they had administered medicines had not been investigated so it was not possible to say whether this was an error in recording or a missed dose.
• Best practice had not been followed. Handwritten records did not always include dosages, or had been signed by two staff to show they had been double checked. Information had not been provided about where

creams and ointments should be applied.
• The medicine audit process was not robust; poor practice was not being picked up quickly and improved.

Learning lessons when things go wrong.
• We were provided with some evidence of lessons learned. Although this was not recorded in full we saw a record of an issue being raised and we were given a verbal account of how practice was changed to keep people safe. Following our feedback the registered manager told us they would keep more detailed records to evidence lessons learned.

The provider failed to keep accurate and up to date records. This was a breach of regulation 17 of the Health and Social Care Act 200 (Regulated Activities) - Good governance.

Systems and processes to safeguard people from the risk of abuse.
• People's relatives said they felt their family members received safe care most of the time. Positive comments included, "Yes staff definitely keep them safe, they have a great relationship with them and that is down to them with their caring and considerate attitude." However, one relative told us, "[Family member] is generally safe but the quality of the carers is quite inconsistent."
• Staff had received safeguarding training and had access to the providers safeguarding policies.
• Staff were able to tell us about the different types of abuse and how they would report any concerns. One member of staff said, "I would report to [registered] if I needed to but I have never been concerned about anything."

Preventing and controlling infection.
• Staff followed procedures to minimise the risk of infection. Gloves and aprons were worn whilst delivering care. One person told us, "They do wear gloves in the kitchen and when administering medication."

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience.
• Most people felt that staff had the right training to meet their needs. However, one relative told us, "Some staff are trained but some of them aren't. I have tried to complain and they have offered more training to those carers. It does concern me."
• Staff received only limited training before they started delivering care. Staff had received one day of mandatory training from an external provider. This training covered 12 topic areas including safeguarding and moving and handling. This meant that limited time had been devoted to each topic. Although some staff had done training in previous employment other staff were new to care and had only this one training session before starting to shadow colleagues.
• Staff induction included completion of the care certificate. Two out of the seven care staff had completed this at the time of our visit.
• One relative we spoke with said, "The quality of carers are inconsistent some carers are impatient and aggravate the dementia." We could not evidence that staff had received training in relation to the specialist needs of people living with dementia. The training records were inaccurate. One member of staff told us they had not completed a dementia course but records showed they had.

The provider had not ensured staff had the relevant qualifications, skills and experience to support people safely. This was a breach of regulation 12 of The Health and Social Care Act 2008 (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. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. Applications must be made to the Court of Protection when people live in their own homes. None were required for the people supported by the service when we inspected.

• The registered manager was able to describe how they made decisions in people's best interest. However, mental capacity assessments were not being correctly recorded and there was no record of best interest decisions in people's care files.

The provider failed to ensure capacity assessments are correctly undertaken and recorded. This was a breach of regulation 17 of the Health and Social Care Act 200 (Regulated Activities) - Good governance.

• People had consented to their care and treatment and this was recorded within their care files. One relative told us, "Care workers always ask for consent before doing things. They say, 'would you like this?' or 'can I do that?'

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• People's needs were assessed before the service started to deliver care. As part of this process the registered manager spoke with the person, their family and their social worker if they had one.
• The registered manager visited people at home to conduct the assessment and ensure the correct level of support was provided. They told us, "I think it's important to look at the house because sometimes what looks like a simple package may be more complex because of the environment. How we support people with moving and handling can be more difficult in some homes and we may have to allow extra time."

Supporting people to eat and drink enough to maintain a balanced diet.
• Staff prepared food for people when this was required as part of their care needs.
• Relatives told us staff supported their family members with eating and drinking. One relative said, "It can be difficult getting [family member] to drink. I tell the carers to try to encourage her to drink and they do."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
• The provider worked in partnership with other health and social care professionals to achieve positive outcomes for people. One relative told us, "If there are any health concerns they notify me, social services and the mental health unit. There is plenty of communication."
• People had regular access to healthcare when they needed it.

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.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Although staff demonstrated caring qualities, evidence throughout the inspection showed the provider was not ensuring the service was caring overall.

Ensuring people are well treated and supported; equality and diversity.
• Staff were kind and patient. One relative told us, "They have the patience of a saint. I have learned a lot form them."
• Some relatives told us there was an inconsistency with staff, others said they had regular staff. People were not provided with rotas so had no idea which staff would turning up at each call. The registered manager told us that wherever possible people were supported by the same staff team. They said, "People can become quite disorientated if you keep changing the staff you send. Other people don't mind so much but we do our best to keep continuity."
• People's religious and cultural needs were taken into consideration. Care plans considered whether people needed escorting to religious events or gatherings. They also recorded any specific cultural needs in respect of dressing, hair, diet or private prayer time.

Supporting people to express their views and be involved in making decisions about their care.
• People were involved in decisions about their care. One relative told us, "[Family member] prefers female staff and they send them."
• People and their relatives were involved in care planning and reviews. One relative told us, "Yes, they asked a lot of questions about [family member's] needs."

Respecting and promoting people's privacy, dignity and independence.
• Staff maintained people's privacy and dignity. One relative said, "They cover her well and her dignity is kept at all times."
• People were encouraged to be independent. Relatives described how staff supported their family members to move around independently using aids such as walking frames. One relative told us, "They let [family member] wash their own face and help them clean their teeth."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People did not receive rotas so they did not always know which staff would be visiting or the exact time of calls. Relatives told us they felt a rota would help. One relative told us, "I asked for a rota but I don't get one so I ask the carers if they are coming the following day."
• Staff were provided with detailed information about peoples' care needs, likes and dislikes so they were able to care for people accordingly. However, some care plan information was inaccurate and other information had not been updated to reflect people's current needs.

The provider failed to ensure records up to date and accurate. This was a breach of regulation 17 of the Health and Social Care Act 200 (Regulated Activities) - Good governance.

• Staff asked people how they would like to be supported to ensure care was delivered in a personalised way. One member of staff told us, "I always ask people what they would like to achieve and then assist them to do this."
• People's individual communication needs were taken into consideration when planning care. Care plans included information such as whether English was a person's first language and whether people had hearing, sight or speech difficulties.

Improving care quality in response to complaints or concerns.
• Relatives felt comfortable raising a concern or complaint. One relative told us, "Any problems you mention once and it's done." However, another relative told us, "When I complained about a disrespectful staff member I was disappointed with their reaction."
• The provider had not followed their complaints policy. Complaints and concerns were not documented and there was no evidence of them being followed up. The registered manager was able to tell us what actions they had taken but this had not been recorded.

The provider failed to ensure complaints were correctly recorded with outcomes and actions taken. This was a breach of regulation 16 of the Health and Social Care Act 200 (Regulated Activities) - Receiving and acting on complaints.

End of life care and support.
• End of life care had previously been provided to one person. The registered manager said they recognised this is a specialist area and didn't want to on more end of life care until they had the right staff who have been fully trained in this area. The package they did take on was solely delivered by a small team of staff, including the registered manager, who were all experienced registered nurses.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider had failed to assess and monitor the quality of their service. Quality monitoring and audits were not taking place. The checks that were being done had not identified all areas of concern or where improvements were needed. Where issues had been identified appropriate action had not been taken to ensure that working practice was changed to make the necessary improvements.
• Records were not being kept up to date. Some information contained within care plans was outdated and inaccurate.

There were not effective systems in place to monitor and improve the quality and safety of the service and complete and accurate records were not being kept. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – good governance.

• The registered manager did spot checks on staff to make sure they were carrying out tasks safely.
• Relatives told us they found the registered manager approachable. One relative told us, "I find I can trust them generally on most issues."
• People were happy with the quality of the care and support they received. One relative told us, "The staff are very friendly, willing to listen to you and build up a rapport. The majority are very patient, they seem to care and have an understanding about [family member's] needs."
• Staff told us they felt supported by the registered manager and positive about their role. One member of staff told us, "Staff morale is good, it is a good team. It has been a learning curve but as the company is new I feel we can make a contribution."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care.
• More work was needed to obtain feedback from people using the service, relatives and staff members.
• Staff meetings were not taking place regularly. One member of staff told us, "Formal staff meetings are supposed to be every three months but this isn't happening. It could be due to us being busy." No staff surveys had been done.
• People and their relatives had not been regularly asked for feedback. The registered manager told us an initial questionnaire was sent four weeks after the provider started to deliver care but only one of the relatives we spoke with had received this.
The provider was not taking steps to assess the experience of people using the service and ensure they were

happy with the quality and safety of the care they received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – good governance.

Working in partnership with others.
• The provider had good links with social workers and district nurses.
• The staff worked in partnership with people and relatives. One relative said, "If I need to speak with anyone I have a contact at the service."

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 Risk assessments were not in place for each identified risk which meant the provider was not doing all they could to minimise risks to people. The provider was not conducting sufficient checks to ensure staff had the qualifications, skills and experience to provide care safely.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not maintaining a record of all complaints, outcomes and actions taken in response to complaints.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not ensuring that robust processes were in place to prevent unsuitable people being employed.

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 17 HSCA RA Regulations 2014 Good governance There were not effective systems in place to monitor and improve the quality and safety of the service and complete and accurate records were not being kept.

The enforcement action we took:

Warning Notice issued giving provider the deadline of 31 July 2019 to be compliant with regulation 17