Panashe Home Care Services Limited

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Inspection report

103 Colby Road
Thurmaston
Leicester
LE4 8LG

Website: www.panashehomecareservice.co.uk

Date of inspection visit:
28 February 2022
01 March 2022
02 March 2022
28 March 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Panashe Home Care Services Limited is a domiciliary care agency providing personal care to people living in their own homes. The service provides support to people living with physical health needs and conditions such as dementia. 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. The service also provides support to a very small number of people living with learning disabilities. At the time of our inspection there were approximately 58 people using the service.

People's experience of using this service and what we found
People were not always safe. Some people were supported by staff who did not always provide care in line with safe and best practice. Some staff were not always caring and their behaviour towards people meant we were not assured people were always safeguarded from harm and the risk of abuse.

There were not enough staff to provide care that people required. Staff were scheduled to provide unrealistic hours of care which meant we were not always assured people received the care and support they needed.

The provider did not have clear oversight of the service. Systems and processes to monitor the quality of care, identify risk and make improvements to the service were not effective.

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

Rating at last inspection and update
The last rating for this service was good (published 19 September 2019).

Why we inspected
We received concerns in relation to overseas staff allegedly working excessive hours and how staff provided care calls to people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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 Panashe Home Care Services Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people not being safe from the risk of harm and abuse, people not receiving safe care and treatment, insufficient staffing, unsafe recruitment practices and how the service is led 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Panashe Home 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. 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by three inspectors 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave a short period of 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 28 February 2022 and ended on 5 April 2022. We visited the location's office on 28 February 2022, 1, 2 and 28 March 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the registered manager, quality manager, senior carers and carers. We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at ten 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
We continued to seek clarification from the provider to validate evidence found. We looked at policies and additional documents. We spoke with an additional two staff members. We also spoke with one person using the service, and with ten relatives of people who use the service about their experience of the care provided. We also liaised with the local authority and other partner agencies.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of harm and abuse. Safeguarding concerns had been raised with the local authority during the inspection alleging unsafe moving and handling practice, and staff being abusive towards people and their relatives. One person's relative told us, "A couple of them [staff] have been a bit rough but it's hard to complain when you don't know their names." We were not assured staff practice did not expose people to the risk of harm and abuse.

● Safeguarding concerns were not always identified or reported. The registered manager understood their responsibility to safeguard adults, but documented evidence to suggest this happened was limited. The local authority and partner agencies raised safeguarding concerns with CQC, but notifications were not always raised by the registered manager. This meant there was a risk safeguarding concerns were not always recognised and responded to accordingly.

● Staff were not always caring. People's relatives told us some staff did not engage or talk much with them. One relative told us, "We never chat. They generally do what they have to do – there's no real caring – just the mechanics of the job." Another relative told us, "There's little conversation and I don't really know anything about them as people. I'm not sure they really understand [person's name]." Some people however felt staff were caring. One relative told us, "They [staff] are friendly and very good." These concerns were identified during inspection and had not previously been raised to the registered manager.

The provider failed to ensure people were always protected from the risk of abuse. This was a breach a regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of safeguarding adults. Staff were able to explain what a safeguarding concern could be and told us they would share their concerns with the registered manager. Staff received safeguarding training and a policy was in place.

Assessing risk, safety monitoring and management

● Care plans were not always accurate. We found some people did not have care plans in place that were reflective of their needs. Some information differed, some information was out of date, while care plans around specific needs such as Diabetes were not in place. One person told us, "I don't know of any care plan and I'm not sure they do either." This meant people may have been exposed to the unnecessary risk of harm and we were not assured staff always knew what people's current care needs were.

● People's risks were not always assessed. We found risk assessments were not always in place and regular reviews did not always take place. This meant staff did not always have up to date and accurate information to allow them to assess, monitor and manage people's risks safely. This placed people at risk of unnecessary

harm.
● Staff did not always follow care plans and risk assessments. We found some staff were recorded as providing their own support when people required the assistance of two staff members. One relative told us, "Sometimes there's only one carer turns up, so I have to help with the lifts." This may have placed people at the risk of avoidable harm, and we were not assured people always received safe care and treatment in line with their assessed needs.
● One relative told us their relative's safety was not appropriately managed due to inconsistencies with when staff arrived to give medicines. One relative told us, "We struggle with the carers around the need to give epilepsy meds at set times. The consequences of mistimed or missed doses can be severe." At the time of the inspection the registered manger had told us there were no people who were prescribed time critical medicines. This meant there was a risk people's care needs were not always known or monitored safely. This placed this person at risk of harm.

The provider failed to ensure people always received safe care and treatment. 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.

Staffing and recruitment
● There were insufficient staff. We reviewed 23 staff members' rotas and found staff were rostered for excessive amounts of hours and given an unachievable number of care hours to deliver within those times. One staff member's total call times equated to 26.15 hours of care planned to be delivered in one day. This was unachievable and meant we were not assured people were receiving the care and support they required.
● Staff were scheduled to provide multiple care calls at the same times. For example, one staff member was scheduled to provide four hours of morning calls to six people, but only had two hours and 15 minutes available to provide this care. This was not an isolated incident and was consistent amongst 23 staff rotas reviewed. A staff member told us they were not told how to deliver care to multiple people at the same time. We were not assured people received the care and support they required and were not assured people were not being placed at risk of avoidable harm.
● Calls to people were inconsistent. Several relatives told us staff time keeping was variable. One relative told us, "Time keeping is not good – they rarely stick to the agreed time." Another relative told us, "They often come either very early or very late." We also found staff were not staying for the full amount of time they were supposed to. This meant we were not assured people always received safe care and treatment, which may have exposed them to unnecessary risk of harm.

The provider failed to ensure there were sufficient numbers of staff to provide care people needed. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Concerns were raised regarding staff who were working from abroad on sponsorship licenses and were at risk of being exploited and made to work excessive hours. We found evidence that supported these concerns and information has been shared with partner agencies including the Home Office, HM Revenues and Customs and the police as part of our inspection.
● Staff were not always recruited safely. We reviewed 12 staff files and found pre-employment checks were not always completed before staff commenced work. Some staff files did not have full employment histories, whilst some did not have appropriate references in place. This meant there may have been a risk people were supported by unsuitable staff.

The provider failed to ensure safe recruitment practices were followed. This placed people at risk of harm. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were provided with training. Inductions were completed for new starters.

Learning lessons when things go wrong

● The provider failed to learn lessons. Concerns had previously been raised by the local authority regarding how calls to people were scheduled. Concerns had also previously been raised about staff manual and handling and the length of time staff stayed to support people. During this inspection we found significant evidence the provider had reverted to previous poor practice and concerns were still being raised.

Using medicines safely

● People received medicines. We reviewed medicine administration records (MARs) which were completed when staff gave medicines. Staff had received training on administering medicines and told us they would contact 111 and the office if they made any errors or had any concerns.

● Staff were trained to administer medicines. Staff explained how they administered medicines and were aware to contact 111 or the GP if they made any errors with people's medicines.

Preventing and controlling infection

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider's infection prevention and control policy was up to date.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Oversight of the service was insufficient. Systems and processes in place to identify concerns and monitor the culture of the service were not effective. People were not receiving care they required in a safe way. People were being exposed to the risk of harm and abuse by staff. Some concerns had been identified but effective action was not taken to improve the service, or the quality of care people received.
- Quality assurance processes were not effective. Audits of incidents were completed but opportunities to drive change and improvements were not taken. This meant people's outcomes and experience of using the service were not always positive.
- Previous concerns were not acted upon. Partner agencies had worked closely with the service to monitor issues with call times previously. The provider was aware complaints of this nature had been raised before. Responsibility had been placed upon staff to undertake the full commissioned call time, but how calls were scheduled by the provider meant staff would never be able to fulfil the full length of the call time. This highlighted the provider's lack of responsibility and limited insight regarding how to manage the service.
- People were at risk of neglect. There were no systems in place to monitor whether people received the commissioned care calls they required. This posed a risk to people's health and welfare as there was a possibility staff could miss visits to people, and the provider would not have any awareness they had not received care required.
- The culture was not always person-centred. While some people's relatives were happy with the standard of care, others were not. One relative told us, "Some [staff] do the absolute bare minimum they can get away with." Another relative told us, "Some of them [staff] are quite good but others, in my opinion, shouldn't be in the job. Sometimes they do the bare minimum and then go."
- Complaints were not always dealt with effectively. People's relatives told us they had made several complaints, but management had not listened and had not affected changes to improve people's care. People felt able to talk to staff but felt their concerns did not result in change. One person's relative told us, "You complain (again) and still nothing's done. The management are not very receptive."
- People's views were not consistently sought. None of the people or their relatives spoken to had been involved in providing feedback about the care that was delivered. The registered manager told us quality assurance questionnaires had been sent out to people, but findings had not been received or reviewed.

The provider failed to ensure effective systems and processes were in place to manage the service. This meant people may have been exposed to the risk of harm, and changes needed to improve the service were

not identified. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Communication was not always open. Some relatives felt communication was not effective and honest when things were not going so well. One person's relative told us, "We had a series of issues about [person's name] not getting the services we expected. They [staff] came up with a list of excuses, [person's name] didn't want a shower today/hair washed'. Although I'm sure that wasn't true it's hard to argue." Other relatives however told us, "They're [staff] reliable and trustworthy."

● People were not engaged in their care. Relatives of people we spoke with consistently told us they had not been involved in reviewing people's care. It was not always clear how people were encouraged to share their views or how care was delivered to maintain people's preferences and wishes. This meant we were not assured care was delivered in a person-centred way by staff who fully understood people's needs.

● Staff had mixed feelings about the management team. Some staff were very positive and felt listened too. Other staff did not share these views or feelings. Some staff felt unable to speak out about their experiences and concerns.

● A registered manager was in post. The registered manager was aware of their responsibilities and to inform the local authority and CQC of any incidents that occurred. Falls and accidents were recorded and reviewed, but it was not always clear if actions taken were effective in reducing the likelihood of incidents reoccurring.

Working in partnership with others

● The service engaged with partner agencies. The registered manager told us they worked with GPs, district nurses and social workers as required. One person's relative told us, "They call the district nurse in if [person's name] gets bed sores."