Proline Care Limited

Proline Care Limited - 4th Floor

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 2 February 2016 and was announced. We gave the provider 48 hours' notice of our visit because the location provides a domiciliary care service; we needed to make sure that there would be someone in the office at the time of our visit.

Proline Care Limited is registered to deliver personal care. They provide care to people who live in their own homes within the community. There were 95 people using this service at the time of our inspection.

The registered manager was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People using this service could not be confident that the registered provider would be able to keep them safe. People were placed at risk because the management of medicines was not safe. There was a lack of clear systems and records to detail what medicines staff were administering. The ability of staff to safely administer medication had not been assessed.

We found that whilst there were some systems in place to monitor and improve the quality of the service provided, these were not always effective in ensuring the service was consistently well led and compliant with regulations. Audits and monitoring systems needed to be improved; these included monitoring of medicine administration and the monitoring and reviews of risks to people. In addition the service had not ensured they had effective systems in place to meet the requirements and guidelines of the Mental Capacity Act 2005. Staff were unsure how to obtain consent from people that did not have the mental capacity to make certain decisions about their day to day life.

You can see what action we told the provider to take at the back of the full version of this report.

People who used the service told us that they felt safe when staff were in their home. Staff we spoke with were able to describe the systems in place to protect people from the risk of abuse. People we spoke with told us there were sufficient staff to provide them with the care and support they required.

We found risk assessments had not been regularly reviewed or updated to ensure the risks to people and staff were minimised. We saw where people had specific health conditions; care records did not always contain enough information and guidance for staff to follow in respect of keeping people safe.

Staff told us they were being provided with the training they required. Specialist training for some specific health conditions experienced by people using the service were not always provided. Staff told us they felt supported and received regular supervision.

People told us they were supported with their nutritional needs. People told us that staff supported them to access a variety of health care professionals when required.

People using the service shared with us that staff supporting them maintained their dignity and privacy and encouraged them to remain as independent as possible. Staff working in the service understood the needs of people they were supporting and providing care for.

Care plans were developed with people and their relative's involvement. Reviews of care plans had not been undertaken regularly to ensure that any changing needs to people's care and support needs were still being met.

There was a complaints procedure in place. Information was provided and people and their relatives knew how to make a complaint or voice a concern.

Summary of findings

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.

Whilst people told us they received their medicines as prescribed. We found medicines records did not detail appropriate information about what had been administered by staff.

Assessments identifying risks were not continually reviewed to ensure they were up to date to keep people safe. Assessments and guidance about people's health conditions were not detailed.

People and their relatives told us they were safe. Staff were knowledgeable about their responsibilities to protect people.

Is the service effective?

Requires improvement

The service was not always effective.

Staff understood how to obtain people's consent when supporting them; however staff were unsure how to act in people's best interest when people were unable to give their informed consent.

Staff received training to support them in their role. We found specialist training was not always provided for specific health conditions experienced by people using the service.

People told us staff prepared meals for them that they enjoyed. People told us that staff supported them to access healthcare support, when necessary.

Is the service caring?

Good

The service was caring.

People and their relatives were complimentary about the staff and the care provided.

People told us their independence, dignity and privacy was respected.

Is the service responsive?

Requires improvement

The service was not always responsive

People and their families were involved in the development of their initial care plans. Reviewing and monitoring of care plans were not undertaken regularly failing to ensure that people's changing needs were identified.

People and their relatives were provided with information about how to make a complaint or raise a concern.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Summary of findings

Quality assurance systems were in place; however some records and audits required for the effective running of the service were not completed or in some instances had failed to identify issues.

People, relatives and staff told us the management team were approachable and available to speak with if they had any concerns.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to ensure the provider could make arrangements for us to be able to speak with people who use the service, office staff, care staff and to make available some care records for review if we required them. The inspection team consisted of two inspectors.

Prior to the inspection the provider was asked to complete a provider information return (PIR). 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 received when we requested it.

Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and any other information we had about the service.

We liaised with a local authority who commissioned services from the provider for views of the service. We used all information to help us plan the areas we were going to focus our inspection on.

As part of the inspection we sent surveys to people who used the service to gather their views. We also sent surveys to people's relatives and staff. Surveys were returned from 12 people and one relative. We spoke with 11 people who use the services and eight of their relatives.

During our visit to the service's offices we spoke with the registered manager, the care manager, one care co-ordinator, two senior care staff and five care staff. We sampled some records, including six people's care plans, two staff files and training records. We looked at the providers systems for monitoring and improving the quality of the service.

Requires improvement

Is the service safe?

Our findings

We looked at how medicines were managed. People that we spoke with told us that staff administered or prompted them with their medicines. One person we spoke with told us, "Staff give me my medicines when they call and they are always on time." We saw that where staff supported people to take their medicines they recorded this in people's daily notes. These records did not indicate what the care staff had administered or the time it was administered. We were unable to establish if the prescribed medicines had been administered correctly. The registered provider had no audit and monitoring system in place to determine safe medicine management. The services system of recording medicines did not meet recognised guidance from the Royal Pharmaceutical Society of Great Britain about the Handling of Medicines in Social Care. Whilst the staff we spoke with confirmed they had received training in the safe administration of medicines; the registered manager advised us that they did not have a system in place to check that staff were competent to administer medicines. This meant that staff had not been assessed as safe to administer medication.

The provider was not ensuring the safe care and treatment of people through appropriate management of medicines and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

People and their relatives told us they felt safe when staff were providing care and support in their home. One person told us, "Yes I feel safe when the carers are here. I have a key safe and carers always leave it safe when they leave me." Another person using the service told us, "If I didn't feel safe I would certainly tell one of the girls [staff]." A relative we spoke with told us, "I feel [name of relative] is safe and well-looked after." Staff we spoke with told us how important it was to keep people safe. A member of staff we spoke with told us, "Before I finish my last calls at night-time, I always check that windows and doors are securely locked and that all equipment is switched off."

Staff we spoke with were able to describe their responsibilities for reporting any concerns that a person may be experiencing some form of abuse. Staff were knowledgeable about the types and signs of abuse that people may present. A staff member told us, "I would report anything I witnessed or if I had any concerns I would go straight to the office." Another member of staff told us, "I would go to social services or CQC [Care Quality Commission] if no-one listened to me." The registered manager told us they would investigate and report the details as necessary to the Local Authority safeguarding team and CQC. The registered provider had a whistle-blowing policy and a confidential hot-line telephone number. Staff we spoke with told us they were aware of the number and could describe how to raise concerns confidently. We saw one incident on a person's record that identified a potential allegation of abuse. We were unable to view records on the day of the inspection to demonstrate that safeguarding procedures had been followed appropriately. Following the inspection we saw evidence that the incident had been reported in accordance with safeguarding procedures.

We looked at the arrangements in place to keep people safe, whilst not restricting their choice and freedom. People told us that staff had assessed the risks associated with their circumstances. One person we spoke with told us, "I have a hoist and there are always two carers." We saw that risk assessments were in place in relation to individual people. However, we found there had been significant gaps in the re-assessing of these records. The registered manager confirmed that risks had not been monitored, changed or updated to minimise the risks to people and staff. This meant that staff may not be aware of the current risk and how to manage it safely.

We looked at the systems in place to deal with accidents and incidents. All the staff we spoke with could describe their responsibilities of how and when to report an incident. The service operated an out of hour's on-call system so that people and staff had access to support and guidance in the event of an emergency. One member of staff told us, "If I couldn't gain access to someone's property, I would ring the office for help." We saw on one person's care records that they required specific support for their health condition. Whilst staff could describe what to do in the event of an emergency, there was no clear or detailed guidance for staff to follow. This information was received following our inspection.

We looked at how staffing levels were determined. People using the service told us they were happy with the staffing arrangements. One person using the service told us, "I have four calls a day and they [the staff] never let me down." The registered manager advised us that they check the capacity of staff hours before accepting new referrals to the service.

Requires improvement

Is the service safe?

This ensured they had enough staff to provide the care and meet people's required level of needs. Staff we spoke with told us the service had enough staff to cover the number of calls people required. The provider stated in the provider information return (PIR) that they provided a safe service by recruiting staff safely. Staff told us and records confirmed that appropriate recruitment checks had been carried out including checking the Disclosure and Barring System (DBS) and references prior to them starting work. One member of staff told us, "I had to provide two references and bring in my documents for my DBS check."

We asked people and their relatives about whether they experienced any delay in receiving support and if the service provided consistent staff to support them. Generally people and their relatives told us that staff were usually reliable and that visits had not been missed. One person told us, "I have the same girls [staff] coming now. They do what they should do and always ask if I need anything." One relative told us, "[name of relative] has regular carers; they stay the right amount of time and are always on time." A second relative told us, "They [the staff] have never missed a call." We saw that the agency had a robust rota system in place that ensured that no calls were missed and alerted the registered manager to any concerns immediately. This meant that people received the care and support they required within a timely manner. We received mixed comments from people about the process staff follow if they were unable to arrive on time for their call. One person told us, "If staff are running late, they always ring me." Another person told us, "Sometimes staff are late getting to me and they do not ring me." All staff we spoke with told us if they were running late, they inform the office staff and / or the person using the service.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us they were happy with the care provided. One person using the service told us, "I'm quite happy with my carers, I would recommend them." A relative we spoke with told us, "My mom receives personal care and staff know what to do. They write notes to each other in the record book." Another relative told us, "I would recommend Proline to anyone."

We spoke with staff about how they were able to deliver effective care to people. All the staff we spoke with told us they received sufficient training to enable them to carry out their job effectively. One member of staff told us, "We have plenty of training on offer here." We saw that one person's care record identified a need for staff to have specialist knowledge for their health condition. We found that staff had not received specific training. However, staff we spoke with were able to describe confidently what actions to take in an emergency and worked in partnership with the person and their family to ensure the persons individual needs were met. We were advised following our visit that specialist training had been arranged. Staff told us they felt supported to do their job. They advised us that they received regular supervision and that team leaders were always available for advice whilst they were working in the community.

Staff we spoke with confirmed that they had received an induction before they started working at the service. A newly appointed member of staff told us, "I did a four day training course and then started my care certificate [a nationally recognised induction process for new staff]. I also observed staff for four days before I worked on my own." This demonstrated that staff were inducted into their roles.

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 when it is in their best interests and legally authorised under the MCA. We checked whether the service was working within principles of the MCA.

Some staff we spoke with had received training in relation to the Mental Capacity Act 2005. We spoke with staff about how they gained consent from people before providing any support. One member of staff told us, "I just explain and ask people if it's okay to do something." Another member of staff told us, "If people can't communicate verbally, they can still let us know if it's a yes or no." People's mental capacity levels were not always reflected in their care plans. Staff were not clear how they should gain people's consent if people could not make decisions about their daily life. We saw in one person's care plan that staff supported them using a specific piece of equipment. We did not see evidence that the person had given consent for this equipment to be used.

People told us that staff made meals for them which they enjoyed. One person using the service told us, "They [the staff] do my breakfast nicely, just how I like it. I'm not rushed at all." Another person told us, "I tell the staff what I want to eat and drink and they make it how I like it. They even make me sandwiches to take to the hospital when I have to visit." A member of staff we spoke with told us, "I don't do any meal preparation, [as the people they worked with did not need this] but I always make sure I offer a cuppa before I go."

People told us they were supported to maintain and look after their health and well-being. A person we spoke with told us, "Oh yes the staff have contacted the doctor if I've asked them to and they arranged for the district nurse to come in to assess me for incontinent aids." Another person told us, "Staff are very confident and knowledgeable when supporting me with my health condition."

Good

Is the service caring?

Our findings

People told us they had positive relationships with staff who supported them in their own home. One person we spoke with told us, “They [the staff] are nice and polite, they listen to me. Another person told us, “I have the finest carers. I wouldn’t be without them.” We also spoke with a relative who told us, “[name of relative] loves them [the staff] to bits. Always saying ‘I’ve got the best carers in the world’.”

Staff that we spoke with had a good understanding of people’s needs and individual preferences. Staff were able to describe how they cared for people in a dignified way. One member of staff told us, “I talk to people and explain what I’m doing. I’m in somebody’s home, so I’m respectful of that.” Another member of staff told us, “I knock on the door and don’t just barge in.”

People told us they were routinely involved in planning how their care needs were to be met in line with their own wishes and preferences. One person using the service told us, “The carers work around me really. I make all the decisions of how I want my care provided.” The staff we spoke with told us they enjoyed supporting people and they could describe people’s health and personal care preferences and preferred routines.

People told us that staff respected their privacy. A person using the service told us, “Staff always give me private time in the bathroom.” Another person we spoke with told us, “Staff respect my home, I like that.” A relative we spoke with also told us staff respect their relative’s privacy, “My relative does their own personal care. They wouldn’t let them [the staff] in the shower with them.” A second relative told us, They [the staff] always cover my relative with a towel to protect their modesty.”

Staff had a good appreciation of people’s human rights. A member of staff told us, “People have the right to keep their independence. I let them do as much as possible, for example, their own intimate personal care.”

Staff told us they were aware of the importance of confidentiality. One member of staff told us, “I do not speak about people outside of my work.” Another staff member we spoke with said, “We don’t disclose people’s key codes to anyone, it is private information.”

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us they received the care they wanted. One person using the service told us, "I prefer male carers and it is what I get. He is fantastic." Another person told us, "I make all my own decisions and tell the staff what I want."

We saw and the registered manager told us that a new style of care plan had recently been introduced. These detailed people's personal history and preferences. One person using the service told us, "A social worker introduced me to Proline. I was fully consulted about my care needs and was involved in my care plan." A relative we spoke with told us, "One of the office staff asked for a profile of our family, so they know mom's background and what to talk to her about." A second relative told us, "My husband has an updated care plan. We keep all the papers in a folder Proline have given us."

The registered manager told us that care plans should be reviewed every 12 months. We saw care plans and found this had not happened. Care plans had been completed for each person when they first began using the service. However there were significant gaps between the initial care plan and the date of the current review. This did not assure us that people's care plans and needs were continually updated to ensure the right care and support was provided.

People we spoke with told us staff knew their preferred routines. One person using the service told us, "Staff have supported me and my family for such a long time. They know us all well and know what to do." Staff we spoke with spoke with confidence about people they supported. One member of staff told us, "[name of person] only like's male carers, it is very important to him and his family." Another member of staff told us, "I love to listen to [name of person] stories about when she was younger and life with her family."

Although the service was not responsible for ensuring that people had activities, some people received support from staff to engage in their chosen hobbies and interests or to access the community to prevent social isolation. One person using the service told us, "Staff take me to a day centre and on occasions we go shopping." A member of staff told us, "I went with [name of person] to view a new property she was interested in." Another member of staff told us, "I've taken a person swimming."

People told us that staff were an important part of their life. One person told us, "Staff support me and my family; they are like an extended family. They have a great relationship with us all." A member of staff we spoke with told us, "If [name of person] has a visitor whilst I'm there, I'll work around them because visitors are so important to her."

The service had a procedure in place about how to make a complaint or raise any concerns. The registered manager indicated that all people who used the service had received a copy of the complaints procedure. One person using the service told us, "If I wanted to make a complaint, I would ring the office. I never have though." A relative we spoke with told us, "I've no complaints, if I did I would just tell [name of manager]."

People we spoke with told us they were able to report any concerns they had. A person we spoke with told us, "I have no problems voicing my concerns and I've been told who to contact if I have any. I have all the telephone numbers." The provider stated in the provider information return (PIR) that they promoted a culture that enable staff to discuss concerns or issues with senior managers.

Staff we spoke with told us that they felt confident to discuss concerns. We saw information displayed around the services office describing procedures and contact numbers.

Requires improvement

Is the service well-led?

Our findings

The management team were receptive to feedback provided about the lack of effective systems in place to monitor the quality and safety of the service provided. Quality audits had not identified or addressed any areas of concern. There were no systems in place to analyse trends when accident and incidents had been reported to prevent the likelihood of further occurrences for people. There were no systems in place to check that staff competency had been assessed to provide some assurance that people were safely supported. Internal audits had failed to identify that there were significant gaps in the monitoring and reviewing of people's individual risk management plans and care records. We saw records lacked content and guidance. The service was not compliant with the Mental Capacity Act 2005 in how they assessed and supported people who lacked mental capacity. In addition we were unable to establish if complaints received had been dealt with appropriately or in a timely manner. Any complaints that had been received were not audited or analysed to identify trends or used to drive continual improvements to the service.

The provider stated in the provider information return (PIR) that they undertake regular spot checks when staff are working in the community. There was no evidence to demonstrate the checks had been done regularly. The service did not have an effective system in place to determine and assess the competency of staff providing support and care.

Our discussions with the registered manager during our inspection showed that they had not kept themselves up to date with changes to regulations and what these meant for the service. The failure to keep their knowledge current meant that there was a risk that people would not be provided with support and care that complied with the regulations.

These issues regarding good governance of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

People told us they satisfied with how the service was managed. The majority of people knew who the registered manager was. One person we spoke with told us, "I've always found [name of manager] to be approachable and kind." A relative we spoke with told us, "The manager is very good. She is very supportive."

People told us they were encouraged to express their views about the service. One person we spoke with told us, "They [the staff] do ring me to see how things are going." A relative we spoke with told us, "They [the staff] have phoned a couple of times to ask if the service is okay." We saw that the service sent out questionnaires to people and their relatives asking their opinion about the quality of the service. We saw that on the whole the comments received back were positive. The service analysed the feedback and produced an executive summary which was shared with people who use the service. The feedback was utilised to make improvements and develop future plans for the service.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The provider understood their legal responsibility for notifying us of incidents and injuries that affected people who use the services.

The service had a clear leadership structure which staff understood. The registered manager advised us of the plans the service were in the process of making to improve how they operated the service and how they intended to make it more effective. For example, the registered manager told us about a new computerised system which was being introduced within the organisation. It was intended that the system will enhance communication between people who use the services and the providers of the service. Staff we spoke with were able to describe the changes that had been made which demonstrated transparent and open communication within the organisation. Staff told us and we saw that staff meetings were held on a regular basis.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 provider had failed to ensure that care was provided in a safe way for people who used the service. 12(2)(g) The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to provide systems or processes that were established and operated effectively to ensure compliance with the regulations. The provider did not have robust systems in place to monitor the quality and safety of the service. Regulation 17 (1) 17(2)(a) The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17(2)(b)