Promises of Care Limited

Promises of Care

Inspection report

80 Darlington Street
Wolverhampton
West Midlands
WV1 4JD

Tel: 01902587099
Website: www.promisesofcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Promises of Care is a domiciliary care service providing personal care and support to people in their own homes. They were providing a service to 25 people at the time of inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not being provided safe care and treatment. Risks to people's safety and health were not assessed or mitigated which exposed them to the risk of harm. Medicines were not given as prescribed and the guidance for staff was not effective leaving people at risk of their health deteriorating. Staff were not always wearing personal protective equipment as required and no risk assessments were completed for people or staff in relation to Covid-19.

We found significant concerns about the management of the service. Their systems were either not in place or not effective to assess, monitor, and improve the quality and safety of the service. The systems had failed to ensure risks were properly assessed, documented and mitigated. The provider had failed to ensure care staff had guidance in place to provide safe care and treatment to people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 Requires Improvement (published 12 June 2019) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulation.

Why we inspected
The inspection was prompted by risk information we held about the service, 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.

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.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to people's safe care and treatment, managing risks to people's safety; governance and oversight of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 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? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Promises of Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of an inspector and inspection manager.

Service and service type
This service is a domiciliary care agency. It provides personal 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. 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 3 March 2021 and ended on 8 March 2021. We visited the office location on 3 March 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with two people and one relative about their experience of care provided. We spoke with five members of staff, including the registered manager who was also the nominated individual, and four healthcare assistants. 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 seven people's care records and multiple medicines records. We looked at two staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at recruitment records, healthcare services correspondence and quality assurance records. We spoke with the local authority.

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 Requires Improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management; Using medicines safely.

- People's risks were not always fully assessed or documented to provide guidance for care staff to support people safely. For example, two people required catheter care to manage their continence needs. There were no specific continence care plans or risk assessments in place for staff to refer to. However, staff had received training and understood how to support people with catheter care and had recorded when continence care had been provided. One person told us "they (carers) help me with my catheter, they make sure the correct bag is on and adjust it so I am more comfortable."
- People's mobility and manual handling needs and risks were not accurately documented to provide information and guidance for care staff to support people safely. For example, two people had care plans stating they were 'bed bound' and unable to weight bear. However, within other sections of their care plans it documented they were able to weight bear with the support of care staff and equipment. This information was inconsistent and increased the risk of harm occurring. Staff had however received manual handling training and understood how to support people with their mobility needs. One relative told us, "carers support (person) with the hoist and electric chair, (person) is safe and they (carers) are very good."
- People with needs and risks associated with diabetes did not have accurate or complete information contained in their care plan. For example, one person had type-1 diabetes and their care plan documented district nurses visited weekly to administer insulin and documented their specific preferred fluid and nutrition needs to manage their diabetes. However, within the nutrition and hydration care plan, it was documented the person "will eat anything" and there was no reference to the person having type-1 diabetes. In discussion with the registered manager about this, they stated the person did not receive weekly insulin injections by district nurses and the person was supported by their family for meals and drinks.
- People's medicine administration records (MAR) were not always complete, recorded accurately, nor administered safely. We found two people were prescribed medicine to manage pain. Their MAR's did not fully reflect the medicines documented in their care plans and did not contain running balances of their medicines or signatures of carers administering the medicines. One person required medicine for pain to be administered "as required" 'and there were no "as required" medicine protocols within the person's medicine file. Both people above were administered their pain medicines before the minimum time allowance for a next dose on multiple occasions. This increased the risk of significant harm occurring.
- One person required their medicine to be administered via a percutaneous endoscopic gastronomy (PEG) tube and detailed instructions were provided to the service by a health professional on how to prepare and administer medicines safely. This information was not documented accurately and consistently in the person's care plan and therefore we could not be assured care staff were administering the person's medicines safely.

We found the provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance was not in place for staff to follow to keep people safe and people were left 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 provider responded to our feedback following inspection by submitting an action plan to us and confirmed medical advice had been sought for the people who had been administered medicines before their next dose was allowed. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

Preventing and controlling infection
● We were somewhat assured the provider had effective infection control procedures in place. However, individual risks associated with Covid-19 had not been assessed for people.

We recommend the provider includes additional risk measures associated with Covid-19 within their infection prevention and control policy and complete specific Covid-19 risk assessments for all people that use the service and care staff employed.

● People gave mixed reviews regarding the use of personal protective equipment (PPE) by care staff. Two people told us care staff sometimes did not wear aprons when providing personal care. A relative told us, carers wore the correct PPE all the time.
● Staff had received training for infection prevention and control and in how to use PPE safely. Staff were able to describe what PPE they should use and when to use it.
● The provider had infection prevention and control policies in place.
● Staff received weekly covid-19 tests which was recorded by the provider.

The registered manager shared an action plan with us, describing the measures they would take regarding managing their infection prevention and control practices.

Staffing and recruitment
● People were not receiving care and support from consistent members of staff and at consistent times. One person told us, "There are so many different staff who come to visit me." Another person told us, "There are a lot of different staff, I don't know who is coming or going or what time they are coming."
● Staff were not inducted into their care roles to the current Care Certificate standard. Care staff had completed an induction booklet to demonstrate their competencies, however these were based on outdated standards and not in-line with current requirements and best practice.

We recommend the provider updates their induction policy and ensure care staff are inducted to the current Care Certificate standard.

● Staff were not always recruited safely. Employment checks were not fully completed. One staff member had gaps in their employment which the provider did not provide an account for. References and proof of identity were checked. Disclosure and Baring Service (DBS) checks had been completed which help to prevent unsuitable staff from working with people who are vulnerable. The Disclosure and Barring Service helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People felt safe with the care and support they were provided and knew how to raise concerns. One

person told us "Yeah I feel safe, I've got no worries, I had one problem and spoke with the manager and it was dealt with quickly."
● Staff had completed safeguarding training. Staff we spoke with understood their safeguarding responsibilities and knew how to raise concerns.
● The provider had appropriate policies and systems in place to raise safeguarding concerns.

Learning lessons when things go wrong
● The provider had systems in place to deal with incidents, accidents and complaints. However, the provider did not always follow through on concerns they identified. One staff member was given a written warning for being late and failing to wear the correct PPE. The staff member was later found again not using PPE appropriately, however the provider did not address this further.
● Staff understood their responsibilities to raise concerns with the registered manager and external agencies and knew how to do this if required.

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection the provider had failed to ensure the systems in place to check the quality of the service were effective and actions were not always taken to address any concerns identified. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider was still in breach of regulation 17.

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; Working in partnership with others

● The provider had failed to ensure people's continence needs were fully assessed and care planned for. Care staff were not provided with information or guidance on how to support people with their individual needs relating to catheter care. There were no specific continence risk assessments or care plans in place. The provider's auditing and governance systems had not identified these failings. This increased the risk of significant harm occurring.

● The provider had failed to complete accurate assessments and care plans for people's manual handling and mobility needs. Care staff were provided with inconsistent information and guidance relating to people's mobility needs. The provider's auditing and governance systems had not identified these failings. This increased the risk of significant harm occurring.

● The provider had failed to accurately document people's needs and care relating to diabetes management. Risk information and guidance was inaccurate and there were no specific diabetes risk assessment or care plans in place for staff to follow. The provider's auditing and governance systems had not identified these failings. This increased the risk of significant harm occurring.

● The provider had failed to administer medicines safely and maintain accurate and complete records. People were administered medicines for the management of pain before the minimum time allowance on multiple occasions. For example, one person was administered paracetamol on at least 29 separate occasions between 17 December 2020 and 31 December 2020 before the four hour minimum time allowance before a next dose. Staff were not provided information and guidance on the safe administration of these medicines. MAR records were inaccurate and incomplete and auditing of medicines records was ineffective. This increased the risk of significant harm occurring.

● The provider had failed to ensure care associated with percutaneous endoscopic gastronomy (PEG) tubes was safe. One person required food and drink via a PEG tube. The person had a risk assessment in place,

however there was no care plan to guide care staff on how to support and monitor the person's PEG tube, what their nutritional requirements were or how to escalate concerns if required. The provider's auditing and governance systems had not identified these failings. This increased the risk of significant harm occurring.

● The provider had failed to use their own risk assessment tools accurately. One person required care for a pressure sore. The person's skin integrity risk assessment identified them as a different gender and age compared to their care plan, leading to inaccurate risk scoring of their skin integrity. The provider's auditing of care records and managerial oversight of these risks were ineffective placing people at risk of significant harm.

● The providers auditing and governance systems had failed to identify where staff had not been completing care records. Missing care call times and signatures of staff delivering care was not identified by any audit. This meant we could not be assured people were receiving the care required as documented in their care records and that audits had been completed.

● The provider was working with the local authority to improve the quality of care at the service by submitting action plans. However, we identified actions required to improve care had not been achieved or sustained but were signed off by the provider as being completed. This did not provide the local authority with an accurate account of the care being provided by the service.

● The provider's auditing and governance systems were ineffective in identifying and addressing the failings reported above. This meant the provider did not have oversight on the quality of care or where improvement was required in the safe care and treatment of people using the service.

We found care and governance systems and processes had not been established and operated effectively to keep people safe. This placed people at risk of significant harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the findings by submitting an action plan to us. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

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 registered manager and provider understood their legal requirements. We found that there were systems in place to record, investigate and feedback on any incidents, accidents or complaints and people were asked if they were satisfied with the outcomes.

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

● People were encouraged to express their views about the service. We saw client feedback forms had been received and people told us the registered manager contacted them to see if they were happy with the service they were receiving.

● Staff had staff meetings and supervisions which they told us enabled them to put forward their views.

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 provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance was not in place for staff to follow to keep people safe and people were left at risk of harm.

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 Care and governance systems and processes had not been established and operated effectively to keep people safe. This placed people at risk of significant harm.

The enforcement action we took:

We imposed a condition on the Providers registration