

Promises of Care Limited

Promises of Care

Inspection report

80 Darlington Street
Wolverhampton
West Midlands
WV1 4JD

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

Date of inspection visit:
30 January 2018

Date of publication:
16 April 2018

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

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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. At our previous inspection on 21 and 24 November 2017, we found people were not protected from the risk of potential abuse. The service was rated as requires improvement and placed into special measures. After that inspection we received concerns in relation to management of the agency, the use of unskilled staff and an allegation of practices that caused injuries to a person who used the service. As a result we undertook this focused inspection to look into these concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Promises of Care on our website at www.cqc.org.uk

At this inspection we found the provider had not taken sufficient action to improve the quality of the service and people remained at risk. The risk to people was not managed effectively as staff did not always have access to detailed information about how to reduce the risk of harm to them. The inappropriate use of personal protective equipment placed people in danger of cross infection. The service remains rated as requires improvement and remains in special measures.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

This service is a domiciliary care agency. It provides personal care to people living in their own home. It provides a service to older adults, younger disabled adults and children. On the day of our inspection visit to the office the agency was providing a service to six people. All of these people were receiving personal care.

The agency had a registered manager who was also the registered provider. 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 a legal responsibility for meeting the

requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The risk to people was not managed effectively as staff did not always have access to detailed information about how to limit risks. The inappropriate use of personal protective equipment placed people in danger of cross infection. The provider had not taken any action to ensure people were not placed at risk of discrimination.

The provider had not taken any action to improve the governance with regards to monitoring the quality of the service provided to people. People therefore, remained in jeopardy of receiving a service that did not meet their specific needs.

Since the previous inspection the provider had taken action to improve the management of accidents and to reduce the risk of a reoccurrence. The provider had also reviewed medicine practices to ensure staff had an understanding about how to support people to take their medicines safely. People were cared for by sufficient numbers of staff who had been recruited safely.

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 remains as requires improvement in Safe.

We could not improve the rating for Safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Prompt action was not taken to safeguard people from the risk of potential abuse and this placed them at further risk of harm. Risk management was compromised because staff did not always have access to sufficient information about how to reduce the risk to people. The inappropriate use of personal protective equipment placed people at risk of cross infection.

People were cared for by sufficient numbers of staff who had been recruited safely. Systems and practices had been reviewed to improve the management of people's prescribed medicines.

Requires Improvement ●

Is the service well-led?

This service remains as inadequate in Well-Led.

We could not improve the rating for well-led from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The provider had not reviewed their governance to improve the quality of service provided to people. Quality assurance systems were inconsistent to ensure people had a say in how the agency was run.

People's preferences for having the same gender staff work with them was not respected. The provider's governance did not ensure people would be protected from the risk of potential abuse. The provider had not taken sufficient action to comply with the breach of regulations identified in their previous inspection report. The provider had developed links with other healthcare agencies to assist in providing care and support for the individual.

Inadequate ●

Promises of Care

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.

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

As part of our inspection we spoke with the local authority about information they held about the agency. We also looked at information we held about the provider to see if we had received any concerns or compliments about the agency. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the agency.

We undertook an announced focused inspection of Promises of Care on 30 January 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 21 and 24 November 2017 had been made. After the previous inspection we received further concerns about the management of the agency. We inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements.

Some improvements were required in the remaining Key Questions. Through our on-going monitoring and at next inspection visit these will be looked at more closely. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection. The inspection was undertaken by one inspector. During our inspection we spoke with three relatives who spoke on behalf of individuals who used the service. We also spoke with two staff members and the registered manager. We looked at care records, records relating to staff training and quality monitoring systems.

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns shared with us after our comprehensive inspection carried out in November 2017. At the previous inspection this key question was rated 'requires improvement.'

With reference to our previous inspection visit we found that lessons were not learned in safeguarding people from the risk of potential harm. The delay on acting on concerns placed people's safety and welfare at risk. Risk assessments did not always provide staff with sufficient details to support their understanding about safe working practices.

At our previous inspection in November 2017, a person alleged their relative had sustained injuries whilst staff assisted them with their mobility. We found that the registered manager had not taken sufficient action to limit the risk of this happening again. The registered manager confirmed these concerns had not been shared with the local authority safeguarding team for this to be investigated. After our inspection the same person raised further concerns of more injuries they alleged their relative had sustained. At this inspection we spoke with the registered manager about this further allegation. The registered manager said this allegation had been shared with a senior member of staff in their absence on 10 December 2017. They acknowledged this member of staff had not taken the appropriate action to safeguard the person from the risk of further harm. They had not shared this information with the local authority safeguarding team for this to be investigated. The registered manager confirmed when they returned to work on 18 December 2017, they informed the local authority of this allegation and we saw evidence of this. That meant prompt action had not been taken to safeguard the person from further harm. We asked the registered manager what action they had taken to ensure this staff member and their remaining staff team were aware of their responsibility of safeguarding people from harm. They confirmed they had not taken any action to improve staff's understanding. This meant people could not be confident that immediate action would be taken to ensure their safety and welfare.

We found at our previous inspection that some people's risk assessments did not provide staff with sufficient information about how to manage risks appropriately. At this inspection we looked at a risk assessment where we had received concerns about how staff assisted a person with their mobility. The registered manager informed us that the person had sustained injuries whilst staff transferred them onto the toilet. However, the risk assessment did not provide staff with information about how to do this safely and the registered manager confirmed the absence of this information. The assessment did not include essential information relating to the person's diagnosis which could have an impact on their mobility. The assessment also failed to identify how many staff were required to support the person. This showed that staff had not been provided with sufficient information to support their understanding about how to assist this person safely. The registered manager said they no longer provided a service to this person.

At our previous inspection two people had raised concerns about practices that compromised prevention and control of infection. This was due to the inappropriate use of personal protective equipment [PPE] such as disposable gloves. For example, we were informed that staff did not always change their disposal gloves

after carry out 'dirty' tasks. At this inspection the registered manager assured us that staff were now provided with sufficient PPE. One out of three relatives we spoke with continued to have concerns about the use of PPE. They told us their relative required support to manage their continence. However, they told us that staff often only wore one disposable glove whilst they assisted the person. They raised concerns about the risk of cross infection. The registered manager said during their spot checks they would observe whether staff were using their PPE correctly to reduce the risk of cross infection. However, the registered manager confirmed they had not carried out any spot checks since the last inspection in November 2017.

Accidents were now managed more effectively to reduce the risk of further harm to people. We observed that an accident report showed what action had been taken following an incident. For example, staff had called an ambulance when they were unable to safely lift a person from the floor. The registered manager had made a referral to an occupational therapist to review the person's mobility and establish whether the person required further equipment to assist them with their mobility. This showed that the registered manager was now aware of their responsibility of ensuring action was taken to reduce the risk of further accidents.

People were cared for by sufficient numbers of staff. We spoke with two people who confirmed their relative required two staff members to meet their needs and this level of staffing was always provided. At our previous inspection the registered manager confirmed there were 15 staff working for the agency to provide care and support to 12 people. At this inspection the registered manager informed us they were providing a service for six people and still maintained the same number of staff.

People were cared for by staff who had been safely recruited. At our previous inspection the staff we spoke with confirmed safety checks were carried out before they commenced working for the agency. We saw evidence of Disclosure Barring Service [DBS]. DBS assists the provider in making safe recruitment decisions. Staff also informed us that references were requested and we also saw evidence of these. The registered manager confirmed that no new staff had been recruited since our last inspection visit. This showed that safe procedures were in place to ensure staff were suitable to work with people in their home.

At our previous inspection people confirmed they had not experienced any missed calls. However, after our inspection visit to the office we received concerns from one person relating to late and missed calls. The registered manager said they had informed this person that staff were unable to attend a visit due to inclement weather as this would have implications on staff's safety. They confirmed the local authority had been informed about them not being able to attend this visit. The registered manager said they were also unable to provide support for this individual whilst they were on holiday because there was insufficient accommodation for staff. At this inspection we spoke with three relatives who confirmed they had not had any missed calls. This meant people did receive support when needed.

The registered manager had taken action since our last inspection, to improve the management of medicines. At our previous inspection two out of four care records we looked at did not contain information about how to support people to take their prescribed medicines. At this inspection we found that the registered manager had provided additional information about the safe use of oxygen and staff were now required to sign to show when they had supported the person with their oxygen therapy. This meant systems were now in place to promote safe medicine practices.

Prior to our inspection in November 2017, we were informed of concerns about a person found wearing two medicine patches when they had been prescribed to wear one. This medicine patch was prescribed for the treatment of pain. The registered manager informed us they no longer provided a service for this person. However, for the future they had introduced a form for staff to sign and date when a patch had been applied

and removed. A body map was also in place to show where the patch had been applied and to ensure the patch is applied to alternative areas of the body. The registered manager said two staff were required to sign the form to confirm the medicated patch had been applied safely. The registered manager showed us a form which identified a person's prescribed creams and where they should be applied. This form was signed by staff to show when these creams had been applied. We spoke with two staff members who confirmed they had access to information about how to support people to take their medicines. This demonstrated that the registered manager had taken action to ensure people received their medicines as prescribed.

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns shared with us after our comprehensive inspection carried out in November 2017. At the previous inspection this key question was rated 'inadequate.'

At our previous inspection we found the provider's governance was ineffective in identifying potential abuse and people remained at risk. At this inspection we found the provider governance had not been reviewed or action taken to ensure all staff were aware of their responsibility of safeguarding people from the risk of potential abuse. We found that prompt action had not been taken to safeguard a person who sustained injuries whilst they received care. The registered manager informed us about competency assessments they had carried out to promote staff's understanding to ensure they were aware of how to safeguard people and we saw evidence of these. However, this assessment did not inform staff about relevant agencies to share concerns with. We found that a senior staff member had not shared concerns about potential abuse with the relevant agency to protect an individual. This placed the person a further risk of harm.

With reference to the same person, we found their care plan and risk assessment had not been adequately reviewed or up dated to tell staff how to safely assist them with their mobility. For example, this person had sustained injuries whilst staff assisted them on and off the toilet. However, the risk assessment did not tell staff how to do this safely. This meant staff were not provided with sufficient information to promote the person's safety and welfare.

At our previous inspection people raised concerns about practices that placed their relatives at risk of cross infection. At this inspection the registered manager was unable to demonstrate what systems were in place to monitor staff practices to reduce the risk of cross infection.

At our previous inspection the registered manager confirmed spot checks were carried out to observe staff's care practices and this was confirmed by people who used the service. We had identified shortfalls with regards to the quality of service provided to people. Since that inspection we had received further concerns about the service. For example, it was alleged that some staff were unskilled and the agency was poorly managed. We discussed this with the registered manager who said they had not carried out any spot checks since their last inspection to review and monitor the quality of service provided to people. One relative said, "The major factor is staff training because they don't always seem to know what they are doing." They continued to say, "Strange because just before your inspection in November 2017, someone from the office used to phone to see if everything is OK but that has stopped." They said, "If you have any concerns you have to phone the office several times before someone answers the phone. This is worrying if you have an emergency." We the Commission also experienced difficulties in contacting the agency. This meant people remained at risk of not receiving a service that meets their specific needs.

We spoke with two staff members who confirmed they had access to training. The registered manager showed us a staff training matrix that identified what training staff had received. However, the registered manager was unable to demonstrate that skills learnt were put into practice because there was an

inconsistent approach in carrying out spot checks. This meant that they could not be sure that staff were competent in their roles.

At our previous inspection we identified that people may not be protected from the risk of discrimination. This is because the provider's governance did not explore equality, diversity and human rights in the care assessment. One relative continued to have concerns about their female relative being cared for by two male staff. Discussions with the registered manager confirmed they had not taken any action to address this. Therefore, people could not be confident they would receive a service the way they liked.

People who used the service were encouraged to have say about the service they received. Surveys were given to people to complete. We looked at three surveys of which two provided positive comments. One of these surveys raised concerns about the lack of communication. The registered manager informed us to resolve this concern; weekly telephone calls were made to people to find out if they were happy with the service. However, one out of two people we spoke with confirmed they had not received a telephone call since November 2017. This meant the monitoring of the service was inconsistent.

The provider has not taken sufficient action to comply with the Health and Social Care Act 2008 (Regulated Activities) since April 2017. This meant people remained at risk of receiving a service that does not meet their specific needs. A further comprehensive inspection will be carried out in due course to determine what further action may be required.

This is a breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we had received an allegation from a person who had recently used the service. They raised concerns about the registered manager's approach in relation to the inspection we carried out in November 2017. The registered manager denied this allegation. They informed us that before they offered a service to people they had informed them of their inadequate rating. They said this was to give people the option to whether they wanted to use the service. However, we spoke three relatives who were unable to confirm this conversation had taken place. These people were unaware of the provider's rating and how this could impact on the quality of service provided.

After our inspection visits in April and November 2017, the provider had failed to conspicuously display their rating on their website and they were issued a fix penalty notice. The provider had now taken action to address this.

We spoke with people about the culture of the service who described it as, "friendly and caring." The registered manager said, "All my staff enjoy their job and are very committed." They said their aspiration for the future was to have a mixed ethnic and gender staff team. This would influence a more diverse service. A staff member said, "We always put the people who use our service first."

The registered manager said a number of staff member's first language was not English. They had identified that staff needed additional support to improve their English language to enable them to communicate more effectively. These staff members had been allocated time to attend an English and maths class to improve their communication skills. This showed effort had been made to ensure staff had the skills to communicate more effectively with people who used the service.

Staff members were actively involved in developing the service. A staff member told us regular meetings were carried out. This enabled them to discuss the service provided to people and where improvements

were needed. One staff member informed us that people had raised concerns about staff's approach. They said during a meeting, the registered manager reminded staff of the importance of engaging with people so they felt valued.

The registered manager confirmed they maintained positive links with other agencies to improve the quality of care provided to people. The care records we looked at evidenced the involvement of other healthcare agencies. For example, one record showed that the registered manager had liaised with a GP about concerns relating to a person's mental health needs and newly prescribed treatment. This link with the GP ensured they were aware of the person's mental health needs and how to support them.

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 | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider had not taken sufficient action to ensure people receive the appropriate care and support. Risk was not managed effectively to ensure people's safety and welfare. The inappropriate use of personal protective equipment placed people at risk of cross infection.</p> |
| Regulated activity | Regulation |
| Personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider had not taken sufficient action to improve their governance to ensure people received a safe and effective service. The provider had not taken enough action to address the breach of regulations identified at the previous inspection.</p> |