ProCare Solutions Limited

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Inspection report

6 Station Road
Codsall
Wolverhampton
West Midlands
WV8 1BX

Tel: 01902276541

Date of inspection visit:
08 June 2017

Date of publication:
18 July 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 7 March 2017 and found we found people did not always receive their agreed levels of support and staff felt under pressure to deliver this. We could not be assured the provider acted in an open and transparent way with us during the inspection. We could not be assured staff received the necessary training to support people. Following the inspection we held a meeting with the provider and told them they must send us an action plan to tell us what action they were taking to make the necessary improvements.

We undertook this focused inspection on 8 June 2017 due to receiving information of concern and to check if the provider had taken any action following our last inspection to drive improvement. This report only covers our findings in relation to the safety and welfare of people. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ProCare Solutions on our website at www.cqc.org.uk
This service provided care in people's homes in the South Staffordshire area to older people. At the time of the inspection 12 people were being supported by the service.

There was a registered manager in place. 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.

People we visited did not receive their agreed levels of support and calls were missed by the provider. When calls had been missed we had not received notification of these incidents in line with our requirements. We could not be sure the provider was open and transparent with us as we received differing information about the people they supported and the hours they delivered, potentially placing people who used the service at risk.

When individual risks had been identified for people we could not be assured staff had the training or information to keep them safe. Risks assessments and care plans were not always in place as required. When people needed support with medicines we could not be sure people had received these as required as tablets were found in previous supplies of blister packs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. 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

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.
People did not receive their agreed levels of support and calls were missed by the provider. The provider had not notified us in line with our requirements of these incidents. We could not be sure the provider was fully aware of the amount of care hours that were needed to be delivered to people. The local authority and relatives confirmed inaccuracies with the information the provider had given us. People did not always receive their medicines as prescribed and there were no medicines administration records in place. When individual risks to people had been identified we did not see risk assessments in place to support this .We could not be assured staff had the training or information to keep them safe.

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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 visit took place on the 8 June 2017 and was announced. We announced the inspection on the day of the inspection. This was so the provider could provide us with contact details of people who used the service. The inspection visit was carried out by one inspector. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information of concern we had received from the local authority, whistle blowers and members of the public. Prior to the inspection we had been made aware that there were concerns of potential irregularities.We used this to formulate our inspection plan.

On this occasion we did not ask the provider to send us 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. However we offered the provider the opportunity to share information they felt relevant with us.

We used a range of different methods to help us understand people's experiences. We visited four people in their homes and spoke with four relatives or friends of these people. We looked at care records for four people to see if their records were accurate and up to date.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection on 7 March 2017, we found people did not always receive their agreed levels of support and staff felt under pressure to deliver this. This was a breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We also found concerns with how medicines were managed. At this inspection we found the necessary improvements had not been made.

Before the inspection we received information of concern from the local authority and whistle-blowers that people were not receiving their calls from the provider. We received information that one person had three missed morning calls during the week of 1 June 2017. We visited this person who was unable to tell us about their experience however a relative confirmed this to us. They said, "I can't tell you the amount of times they just haven't turned up, I have lost count. Sometimes they ring me after about an hour and say we can't get anyone to you, most of the time it's me ringing them saying no one's here. The office is so poorly managed". We looked at records for this person, it was documented that all calls on the week of the 1 June 2017 had been completed. The relative told us, "They filled all that in on the day they came back, you can tell by the hand writing, I sat here and watched them fill three days in at once".

During the inspection we spoke with four people or their relatives, who used the service. Three of the four people confirmed there were calls that were frequently missed. A relative said, "We had a missed call last week, they were over an hour late before they contacted us. My relation was already up and dressed by then". Another relative told us, "There is no communication from the office it is just chaos". This meant we could not be sure people were receiving calls as required and were potentially placed at risk.

We received further information from the local authority that another person did not receive calls on 27 May and 3 June 2017. The call on 3 June 2017 that was not completed resulted in this person not receiving their medicine as prescribed. This is currently being investigated by the local authority as a safeguarding incident. A relative of this person confirmed that this was the seventh call that had been missed by the provider since they had started delivering the care in late February 2017.

People and relatives raised concerns about staffing levels and the turnover of staff used by the service. One person told us, "You never really know who is coming; sometimes they are off sick or just leave. You have nothing in advance like a rota. They have a lot of different staff; it's a concern". A relative told us, "There are not enough staff. We have different ones all the time, the good ones have left. It's because of the management and the office they feel bullied, the staff come and tell us that. We get nothing in advance so you don't know who is turning up at your house, you don't get introduced they just turn up. You don't know who they are if you are lucky you get a name. I have had all sorts here".

This is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Following our comprehensive inspection on 7 March 2017 we met with the provider. We explained that when calls were missed, they should notify us of that fact. We have not received any notifications in line with our

requirements in relation to these incidents.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider was unable to clarify how many care hours they provided. We have asked for this information on three separate occasions. On these three occasions we have been provided with differing information. However, when we spoke with relatives of the relevant people, one relative confirmed to us that this was inaccurate. Therefore we are not assured that the provider is fully aware of the care hours that need to be delivered to people and we could not be assured the provider acted in an open and transparent way with us.

This is a continued breach of Regulation 20 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

When individual risks had been identified to people we could not be assured staff had the training or information to keep them safe. For example, one person needed support with specialist equipment to support their welfare. Before the inspection we had received information that staff were not provided with the necessary training to support this person. Prior to our inspection we requested training records from the provider for staff who work with this person. We were not provided with any evidence that the necessary training was offered. We spoke with this person's relative who confirmed staff had not had the necessary training. They said, "One girl knew how to do it but since she has gone no one has a clue, I just do it myself now. If you ring the office and ask they tell you the staff are all trained. The staff are lovely but they are not good enough. It's not their fault they are just not provided with the training they need. I have had 14 different staff come here since Christmas to deliver care, it's not good enough". We looked at records for this person and did not see any information relating to this equipment.

Another person needed to wear specialist equipment to support their health. They told us they were concerned as staff did not how to support them to use this. They said, "They all had training when I started using the service, but all those staff have left now. I am able to tell them how to do it but I don't feel I should have to". We looked at records for this person and did not see any information to inform staff about how this should be used.

This is a continued breach of Regulation 18(2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We could not be sure people received their medicines as prescribed. We saw there were tablets in blister packs from previous dates that should have been administered. For example, a blister pack for one person dated 14 March 2017 had the tablets for the Thursday and Friday dose still in situ. For the week of 29 March 2017 all medicines remained in the blister pack except for the Saturday am dose. This meant we could not be sure this person had received these medicines. Furthermore, there was no medicine administration record completed by the pharmacist to go with this person's medicines. We saw there was a chart that had been completed by the provider; this did not have two staff signatures on confirming the medicines as correct as required. On this chart it was also documented that at, '15:30, two tablets should be put out to be taken at tea time'. We did not see a risk assessment or a care plan in relation to this to consider whether the person was able to do this independently. Prior to our inspection we had received whistle blowing information about a significant medicines error that had occurred as a result of medicines being left out for this person. We reported this to the safeguarding team. We spoke with a friend of this person they told us, "Its unsafe, they just leave them on the side; [person] will take them if they remember but more often than not they don't. I have asked for someone to come later and administer them but I don't know what's happening".

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our comprehensive inspection we raised concerns with the provider's recruitment process. We have not reviewed recruitment as part of this inspection as we did not visit the office on this date.

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 18 Registration Regulations 2009 Notifications of other incidents We have not received any notifications in line with our requirements in relation to missed calls.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour We could not be assured the provider acted in an open and transparent way with us.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive their agreed levels of support and calls were missed by the provider. We could not be sure the provider was fully aware of the amount of care hours that were needed to be delivered to people. We could not be assured staff had the training or information to keep people safe.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines as prescribed and there were no medicines administration records in place. When individual risks to people had been identified we did not see risk assessments in place to support this

The enforcement action we took:

Urgent suspension