Precious Hope Health & Home Care Ltd

Precious Hope and Home Care Ltd

Inspection report

7a Cumberland Street
Leicester
LE1 4QS

Tel: 07736950090

Date of inspection visit:
04 April 2022
05 April 2022

Date of publication:
29 July 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Precious Hope and Home Care Ltd is a domiciliary care agency which provides care and support to people living in their own homes. At the time of our inspection there were 106 people using the service, of these 95 were receiving personal care. Care Quality Commission (CQC) only inspects where care workers are providing 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
Care plans did not always contain sufficient information about people's health needs.

The deployment of staff was not always effective at meeting the needs of the people they supported.

Staff did not all have a good understanding of how to keep people safe and not all were up to date in their training of how to keep people safe.

The systems and processes to review care records and oversee the use of medicines was not effective.

We heard from people, their relatives and staff that calls were often delayed or cut short. Systems and processes in place to review call information was not effective as they had not identified these concerns.

People and their relatives gave mixed feedback about the leadership of the service. Some reported successful changes had not been put in place when concerns were identified to the management. Staff gave us positive feedback about the leadership of the service.

People and their relatives told us that people felt safe when receiving care.

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

Rating at last inspection
The last rating for this service was good (published 27 November 2018).

Why we inspected
We received concerns in relation to oversight of staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has changed from good to requires improvement based on the findings of

this inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Precious Hope and Home Care Ltd on our website at www.cqc.org.uk.

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 monitor the service and will take further action if needed.

We identified breaches in relation to safe care and treatment and governance of the service at this inspection.

We sent the provider a warning notice asking them to make changes. When we next return to inspect the service, we will consider what improvements have been made.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Precious Hope and Home Care Ltd

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors attended both days on site. Two Experts by Experience supported with calls to people who use the service and their family members. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care. Two further inspectors made calls to staff, as part of the inspection.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we wanted to give the provider and registered manager opportunity to be in the office to support the inspection.

Inspection activity started on Monday 4 April 2022 and ended on Tuesday 12 April 2022. We visited the location's office on Monday 4 and Tuesday 5 April 2022.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who use the service and 12 family members. We also spoke with 13 staff including the deputy manager, care coordinator, two team leaders and nine care workers. The registered manager and provider were not available to take part in the inspection.

We reviewed a range of records. This included 10 care records, five staff files in relation to recruitment and supervision, and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Using medicines safely

- Medicine administration record (MAR) charts were not always in place. People were supported to have creams applied, but the provider had not completed a MAR chart. This was not in line with National Institute for Clinical Excellence (NICE) guidance, which says all people who are supported with medicines should have a MAR chart. This lack of information put people at risk of receiving medicines incorrectly.
- One person who had recently started their care had care staff providing medicines that were not recorded on a MAR chart. One staff member told us there was, "No-where to record it because there was no care plan. So, I didn't record." This placed this person at risk of not receiving their medicine as required.
- There was insufficient guidance available for staff to ensure safe administration when people needed 'as required' medication. For one person the directions in place were poor quality and did not contain enough information to guide staff about gaps between the medication. This placed this person at risk of overdose of the medicine as the guidance provided was not clear.

Assessing risk, safety monitoring and management

- Care plans did not reflect people's current needs and there was a lack of clear guidance on how to manage people's conditions safely. For example, one person's care plan stated they had been diagnosed with ulcerative colitis. However, there was no further reference to this in the care plan, or any guidance for staff on how to support the person to manage their condition.
- Risks associated with people's care were not always identified and recorded. Where people lived with diabetes, there was limited guidance for staff to enable them to recognise potential risks and signs of deterioration. For example, if blood sugar levels were too high or too low. Some staff we spoke with also had a poor understanding of diabetes. This put people at risk of being supported by care workers who may be unable to detect the onset of serious ill health due to diabetes.

Systems and processes to safeguard people from the risk of abuse; Preventing and controlling infection

- Staff did not always understand abuse, and the forms which it can take. Staff were not consistently able to tell us who they should report abuse to if they had concerns. According to training records, 10 of 49 staff had not received safeguarding in the 12 months before the inspection. This was the time frame given by the provider themselves on their training records. This put people at risk of care from staff who were not always aware of their responsibilities to keep people safeguard people from abuse.

The provider did not always provide safe care and treatment to people using the service. Risks were poorly managed; staff were not always aware of their responsibilities to keep people safe and medicines were not always managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us they felt safe when they received care. Feedback from people was good about the care provided to them. One relative told us, "The carers are brilliant, they are fantastic, and they respect (name), they will talk to (name) and interact with (them). They often go above and beyond."
● We saw evidence safeguarding issues had been reported to the local safeguarding team.
● We were assured that the provider was accessing testing for staff.
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment; Learning lessons when things go wrong
● Staff were not always recruited safely. We reviewed five staff files and found two of these files lacked full employment histories. This meant there was a risk people were being supported by staff who may not be suitable.
● Two care worker's Disclosure and Barring Service (DBS) checks had not been refreshed in the last three years, the time frame set in the provider's own policies for renewal. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. When this was identified, the provider arranged for the DBS check to be completed immediately
● The provider did not effectively deploy staff to meet the needs of the people they supported. We reviewed the rota against the actual times of calls and saw staff frequently cut their calls short and attend significantly early or late. One person told us, "(Staff) just do not stay the length of time they are supposed to and rush in and out. I am pleased to see the back of those carers, as they do not seem to really care."
● Despite what we saw on the rota, many people we spoke to were happy with the timings of calls or did not mind if their calls were early or later than expected. One person told us, "The carers will let me know if they are running late and they always do turn up."
● The registered manager demonstrated the service learned lessons when things go wrong. Where a past incident occurred where calls were missed due to human error, at inspection we saw steps were in place to reduce the risk of it happening again.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Audits and checks of medicines did not identify the shortfalls that we identified on inspection. It had not been identified they were not working in line with National Institute of Clinical Excellence (NICE) guidance, staff should have a check on their competency for medicines every year and all medicines, even where just prompting occurred, should be recorded. This lack of oversight put people at risk of receiving medicines in a way that was not safe and appropriate for them.
- Oversight of records relating to the care and treatment of people using the service was not sufficient. For example, in one person's care plan, who needed a device to support their breathing, it had not been identified there was a total lack of information about the device and why it was important. The absence of systems and processes to detect the lack of detail in this care plan meant staff may not understand how and why to use the device, putting the person at risk of care that was not safe.
- Systems and processes were not in place to identify where staff training had expired. This meant there were many staff with training that was out of date when the services own time frames for training were considered. This put people at risk of care that was not being given by competent staff.
- The system to monitor safe recruitment practices was not effective. Please see the detail of these concerns in the safe key question under 'Staffing and recruitment'.
- Staff did not always receive their annual reviews, regular supervision, or regular spot checks. This meant opportunities to discuss priorities such as the timings of calls, understanding of safeguarding and opportunity to learn lessons when things went wrong, were missed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- Adequate systems for monitoring call times were not in place. The provider failed to monitor calls to people to ensure staff arrived on time and stayed for the required time. Several staff told us they do not have enough time to travel between the calls which meant they felt rushed. As the provider had no oversight of the timeliness of care calls, opportunities to make improvements to the quality of care people received were missed.
- We had mixed feedback from people and relatives about call times and duration. One relative told us about the impact of carers coming early for the evening call and late for the following morning call, "If they arrive for the night call early (person's name) can be sitting in the same pad for fourteen hours, (they have) a skin condition and it is really important for (them) to be clean and (they) can end up with itching skin,

waiting for the carers to come." As the provider had no oversight of the timeliness of care calls, opportunities to make improvements to the quality of care people received were missed.

We found no evidence that people had been harmed however, the systems and processes to review care records and oversee recruitment and the use of medicines was not effective. Systems and processed were also lacking for reviewing and monitoring call times. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Many people were happy with the care they received and would accept inconvenience in the time of their care call as they felt the carers were of good quality. One person told us, "We never receive a rota and do not know who is coming, but I am not bothered as all I want is for the carers to turn up, be pleasant and leave in a good mood." The relative of a person recently supported by the service told us, "I could not find one fault with the agency, the care was perfect, they came in smiling. There aren't enough stars in the sky to say how good they were, they used to brighten our day."

Continuous learning and improving care

● We received positive views from staff about the leadership and office support at the service. One care worker told us, "I appreciate the way they communicate with me, (they) always communicate in time if there are changes (the office is) easy to get in touch with if I need them too."

● People and their relatives reported mixed views about knowing who the registered manager was and how responsive they were to issues raised. One relative told us, "Many a time I have raised the issue of timings with the office, they listen and it's corrected and then things go back to square one" and another relative told us, "I have no idea who the manager is, there doesn't seem to be a proper administration of the agency or any kind of routine." One person told us, "The manager; (name) is always available to talk to on the telephone."

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 service understood the underpinning principles of the duty of candour and had an appropriate policy and procedure in place.

● Staff gave honest information and suitable support and knew how to apply duty of candour where appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Some people reported recently receiving a questionnaire to ask for their views on the care they received. We saw evidence of a questionnaire where less than a sixth of people responded. We saw evidence that the provider had tried to capture people's views in other ways, such as telephone calls.

● We saw evidence that the service worked in partnership with other professionals, for example contacting police and social workers for advice when needed.

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 Safe care and treatment were not always provided for service users

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 The systems and processes to review care records and oversee the use of medicines was not effective.

The enforcement action we took:

Warning notice was issued