Purple Homecare Limited

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Inspection report

Hamilton House, 111 Marlowes
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Tel: 01442450341

Date of inspection visit:
26 April 2019
27 April 2019
01 May 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Purple Homecare Limited is a service providing personal care and support to people in their own home. At the time of the inspection the service was providing support to 8 people. Although the provider was registered to provide personal care from Hamilton House, 111 Marlowe's, Suite 608, Hemel Hempstead HP1 1BB we found that they had moved to another office but had not taken the required steps to amend their registration. This was a breach of the conditions of their registration. We inspected the office they told us they were providing the service from Victoria Square, 2 Fountain Court St Albans, AL1 3TF.

People's experience of using this service: People told us the care they received was reasonable and was provided by a consistent workforce. We found that people were put at risk of receiving care that was unsafe and did not meet their needs.

Rating at last inspection: This was our first inspection since the service was registered on19 March 2018.

Why we inspected: This was a planned inspection.

Enforcement: We are taking enforcement action and will report on this when it is completed.

Follow up: The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
•□Ensure that providers found to be providing inadequate care significantly improve.
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

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. We will have contact with the

provider following this report being published to discuss how they will make changes.

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

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Purple Homecare Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide 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: Purple homecare is a domiciliary care agency providing support 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 attempted to contact the provider on 12 April 2019 to give notice of the intended inspection. However, as the contact details had changed we were unable to contact them. We then established contact with them and gave notice on 17 April 2019 that we would be inspecting the service. The provider informed us they were unable to access their office due to rent arrears. Neither the provider or the registered manager were available to support us with the inspection on the 25 or 26 April 2019. The service was inspected on 1 May 2019.

Inspection site visit activity started on 26 April 2019 and ended on 1 May 2019. We visited the office location on 01 May 2019 to see the manager, there were no office staff in post.

What we did: We reviewed care records and risk assessments and other records relating to the service, including daily log records and complaints. However, there were no records relating to staff training and recruitment. We spoke with five relatives of people who used the service and two staff members one who was employed by Purple homecare and a second staff member employed by the registered managers other service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
• The registered manager confirmed there was no safeguarding systems and processes in place to safeguard people from abuse and avoidable harm.
• The registered manager showed us brief details of a safeguarding concern that had been identified by an external professional. The registered manager was unable to provide details of how this was investigated, or any action taken to safeguard people.
• Staff had not received training in safeguarding people.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider failed to safeguard people from harm and abuse because they did not have systems in place to identify potential harm.

Assessing risk, safety monitoring and management
• Care records contained minimal risk assessments.
• Where moving and handling risk assessments had been completed they were done by someone who did not have the training, skills or experience to carry out the assessment.
• Risks assessments had not been completed in areas where risks had been identified including moving and handling, falls, health conditions and medicines.
• Where risks were identified there was no information for staff on how to mitigate those risks and ensure people's safety. For example. we noted that in all the care records people had partially completed moving and handling risk assessment and falls risk assessments. Each question had been 'scored' to help determine the level of risk. However, the scores have not been totalled and therefore the provider had not been able to assess the level of risk or to put any mitigating measures in place to reduce the risk.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider failed to protect people by assessing risks and implementing measures to mitigate those risks.

Staffing and recruitment
• The provider confirmed that staff had been providing personal care to people without the required pre-recruitment checks, including Disclosure and barring list checks (DBS) and references.

• Application forms were incomplete. There were no DBS, references or evidence that the provider or registered manager had attempted to check the suitability of the staff member before they were in a position to access confidential information.
• Where references had been obtained the provider had not verified these, they were not always on headed

paper and were not from previous employers.
• The provider had not checked whether staff using their vehicles for work had the appropriate insurance to do so.
• New staff did not have any formal induction.
• Three drivers were employed by the service to drive care staff to service users' home. They also had access to peoples care records and knew the times of peoples scheduled visits. However, one of the drivers had no recruitment file at all. The other two drivers had only minimal information. They had access to sensitive and personal information including staff addresses and addresses of people who used the service without appropriate checks in place.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider did not complete pre-employment checks to help assess the suitability of the staff to work in this type of service.

Using medicines safely

• Care staff were assisting people to take their medicines but had not received any formal training or had their competency checked.

Learning lessons when things go wrong
• The registered manager told us there were no systems in place to learn lessons from incidents, accidents, complaints, satisfaction surveys or audits.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: People's outcomes were not consistently good. Some regulations were not met.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.
• The registered manager was aware of their responsibilities regarding the requirements of the MCA. However, there was no evidence that people had had their capacity assessed or that any best interest decisions had been made. We noted that in one care record it said the person had a power of attorney in place, but we were unable to confirm this as there was no evidence to support this statement.
•Staff were unable to demonstrate they understood MCA principles or how they related to their day to day roles. One staff member told us "I have not completed this training yet but will do it online as part of my induction."
• People were unable to confirm if care staff asked for their consent before support and care was provided. Records we reviewed contained no evidence that people had been asked for their consent or that consent was reviewed periodically to determine if people were still happy to consent to all or part of their support plan.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.The provider did not have a process in place to enable them to obtain consent from people who used the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed by the provider who was not qualified to complete care assessments. There were only three one-page care summaries out of eight care records checked. We found although limited care assessments were completed they were not then used to develop a care plan to inform care staff how to properly support people effectively. This meant that care staff were providing care based on their own knowledge of what they thought people needed rather than following the guidance of a care plan.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider failed to develop a personalised care plan to reflect the individual needs, preferences and wishes of people who used the service.

Staff support: induction, training, skills and experience

• People were supported by staff who had not received an appropriate induction or ongoing training to help ensure they had the right skills and knowledge to support people safely and effectively. One person said, "The carers are quite good, and I think they do the best they can. I know [Name of carer] is very new and I think is still learning the ropes."
• Staff were unable to confirm any training they had completed as part of their induction. One staff member told us "I only started working at Purple Homecare last month so am still learning. When asked what the induction consisted of they told us "I went to the office and [Name of provider] talked to me about everything."
• When asked about specific topics including safeguarding people form avoidable harm, moving and handling, mental capacity act and the safe administration of medicines they told us "I have not done these yet."
• This demonstrated that the staff did not have the knowledge to identify potential abuse or harm and could not describe the processes for raising concerns. People were placed at risk of being harmed through poor moving and handling practices, and medicines being administered without staff having their competencies checked. This meant that people were not protected from the risk of possible abuse or harm.
• There were no systems in place to identify individual staff training needs and no processes to monitor when refresher training was due.
• Staff were not supported in their roles. For example, we asked staff about the support arrangements in place to help them carry out their roles effectively. One staff member told us "I can contact [Name of provider] at any time and they will always tell me what I need to know. They were unable to tell us the name of the registered manager when asked they said they had not heard of this person. The provider to whom they referred was out of the country and not contactable due to being in a remote area with little connectivity and intermittent access to internet. This meant the staff member had no management support despite being new to the service and having no prior 'care' knowledge experience or training.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider had failed to ensure that there were sufficient staff who had the competence, skills and experience to enable them to support people safely and effectively.

Supporting people to eat and drink enough to maintain a balanced diet
• Where this was assessed as a need people were supported to eat and drink sufficient amounts to maintain their health and wellbeing. The registered manager told us if they had any concerns about a person's food or hydration intake this would be monitored on a food and fluid chart. However, the care records reviewed did not identify this as a regular assessed need and care staff just assisted with eating already prepared food when required. Most people were supported by family.

Staff working with other agencies to provide consistent, effective, timely care; and supporting people to live healthier lives, access healthcare services and support
•People's relatives supported them with attending healthcare appointments. The registered manager confirmed that generally the people they supported did not require support to access healthcare professionals. However, one staff member told us if they had any concerns about a person's health they would contact the GP.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People were not consistently supported and treated with dignity and respect; or involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People told us that the care staff treated them kindly generally. However, one person's relative told us "[Name of person] does not ask the care staff to do much as they often say it's not their job. For example, the person could use some assistance with practical tasks and with improved communication with the family which does seem to be lacking." Another person's family member told us "[Name of person] has only had service from Purple Homecare for 3/4 weeks. They told us the provider completed the initial assessment. As far as they are aware there have not been any missed visits and thinks the care staff attend regularly. Another family member described the service as 'functional'.
• Staff we spoke with, did not demonstrate any warmth or compassion when speaking about the people they supported. One staff member told us "I am just helping out as they are short staffed." While the other staff member told us, they were doing the job to earn extra money and the job was better paid than where they worked previously.

Supporting people to express their views and be involved in making decisions about their care
• Care staff and the registered manager were unable to tell us about people's involvement in the development or review of their care plans.
• People were not routinely supported or encouraged to express their views or be actively involved in making decisions about their care and daily routines. We noted care records referred to people as 'She' or 'He' and there was no evidence that they were asked how they wished or preferred to be addressed.
• There was no information relating to people life histories, preferred routines, what they enjoyed doing or how they wished to spend their time or be supported. The information was generic, and all the care records contained almost identical assessments.
• For example, we noted in one person's care records it said, the person was 'independent with all aspects of a personal care.' The objectives recorded for that person stated, 'Care staff to support me to maintain a good standard of personal hygiene'. However, personal care was not assessed as a need. We spoke to the registered manger about this and he agreed it was contradictory and may not have been relevant to that service user.

• Respecting and promoting people's privacy, dignity and independence
• Staff were unable to demonstrate that people privacy and dignity was respected and maintained. One relative told us "I think the staff are respectful to be honest I am not there when they are supporting with personal care." When staff were asked about respecting people's dignity and maintaining their privacy one staff member told us "I do not really understand the question, can you say it again."
• The registered manager did not understand their responsibilities in terms of protecting peoples

confidential and personal information under general data protection regulation. For example, during the inspection we found that confidential care records were not kept securely at the registered office. We found records were left in the boot of the driver's car, in the office reception and the registered manager left the office several times during the inspection leaving multiple records on the desk with the inspection in progress.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Inadequate: The service lacked management overview and people's basic needs were met through the knowledge of the staff and not through good organisational management. Some regulations were not met

Improving care quality in response to complaints or concerns
• People were provided with an information leaflet informing them how to complain.
• People and their relatives told us they would know how to complain, should the need arise.
• There was a complaints policy in place to investigate complaints. However, we noted that a spreadsheet contained five entries with very limited information about complaints which had been made.
• The registered manager told us they were unable to find any information about how the complaints had been investigated, any outcomes or lessons learnt.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.The provider did not have adequate systems in place to properly investigate, respond or resolve complaints made by people who used the service.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People and their relatives were unable to confirm they had been fully involved in the development and planning of their family members care and support plans.
• Care plans were generic, lacked detail and personalisation and did not provide adequate information to inform care staff on how to support each person with their assessed needs. Peoples personal preferences were not taken into account. Daily log records were completed by care staff and records captured information about what support had been provided but did not necessarily reflect what had been recorded in the assessment record or one-page care summary.
• People's needs were not routinely reviewed with them, to ensure the care and support being provided was still appropriate, or to identify if there had been any changes to their needs or wishes.
• People were not asked about any interests or hobbies and lacked any assessment in relation to people's social needs. This meant that people could have been socially isolated.
• The service was not flexible in response to peoples changing needs due to a lack of staff availability.
• People told us staff turned up at the expected time. However, on the day of the inspection the registered manager tried to contact both staff members who were on duty without success. Eventually they were contacted, and both had finished their shifts early. This was without the permission of the registered manager or the people they were supporting. However, although the care staff had left early people had their support completed as required.

End of life care and support
• The service was not currently supporting anyone receiving end of life care. There was no record in the assessment in relation to peoples end of life wishes. Staff had not received training to enable them to support people with end of life care.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The provider was operating in breach of the conditions of their registration and had failed to take appropriate action to ensure they were operating lawfully.
• The registered manager confirmed there were no systems in place to monitor the quality of care plans, risk assessments, accidents, incidents, safeguarding, medicines, staff training and competence or recruitment.
• The provider had failed to identify the concerns we found during our inspection.
• The provider had failed to ensure that confidential information was stored securely.
• The registered manager confirmed that they had not been actively involved in the management of the service.
• Staff were unaware who the registered manager was.
• The provider had failed to notify their insurance company of their change of address or that they were operating outside of the conditions of their registration.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.The provider did not have any systems or processes in place to adequately monitor the risks, quality or safety of the service.

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

• There was no evidence of any meaningful involvement or engagement. The registered manager did not demonstrate that they involved people, or staff in any decision making about the service. There was no evidence that the service considered or had considered any of the equality characteristics.

Continuous learning and improving care

• The registered manager was unable to demonstrate any learning or improvements to the standard of care as no quality assurance or audits had been completed.
• The registered manager had not been involved in the day to day running of the service and told us "I was involved initially when the service was first set up. However. I have not been to the service for about three months."

Working in partnership with others

• The registered manager was unable to demonstrate any partnership working with other professionals.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to develop a personalised care plan to reflect the individual needs, preferences and wishes of people who used the service.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have a process in place to enable them to obtain consent from people who used the service.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to protect people by assessing risks and implementing measures to mitigate those risks.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from harm and abuse because they did not have systems in

place to identify potential harm.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have adequate systems in place to properly investigate, respond or resolve complaints made by people who used the service.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have any systems or processes in place to adequately monitor the risks, quality or safety of the service.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not complete pre-employment checks to help assess the suitability of the staff to work in this type of service.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to transfer existing care to alternative providers.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there were sufficient staff of good character and had the competence, skills and experience to enable them to support people safely and effectively.

The enforcement action we took:

We issued an urgent condition to restrict the provider from taking on any new care packages and to

transfer existing care to alternative providers.