Proline Care Limited

Proline Care Limited - 4th Floor

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

Proline Care Limited is registered to provide personal care. The company provides care to people who live in their own homes within the community. There were 210 people using this service at the time of our inspection.

There was a registered manager in post who was present throughout the inspection. 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.

At the last comprehensive inspection this service was placed in special measures by CQC. At the inspection of this service on 4 and 18 October 2016, breaches of six regulations were found in which two of these were in relation to the key question, 'Is the service safe?.' This was because there were insufficient numbers of staff available to meet the needs of people and people often experienced late or missed calls. The management of medicines was not safe which meant there was a risk that people did not get their medicines as prescribed. The overall rating for this service was 'Inadequate'.

This inspection found that whilst there had been improvements in the key area we looked at: 'Is this service safe?' there was not enough improvement to take the provider out of special measures. Another inspection will be conducted within 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.

This report only covers our findings in relation to the key question, 'Safe'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Proline Care Limited on our website at www.cqc.org.uk.

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.

At this inspection people told us that they received their medicines as prescribed. However, there continued to be no consistent approach to providing guidance for staff in respect of the administration of 'as required' medicines. Whilst staff knew about individual risks to peoples' health and well-being and how these were to be managed, we found peoples' care records and supporting documents did not consistently contain sufficient guidance for staff to follow.
People and their relatives told us there had been improvements in the numbers of staff to meet people's individual needs. People told us that they felt safe using the service and that since our last inspection they now received care and support from usually consistent and reliable staff members.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not consistently safe.

People received their medicines as prescribed. However, people who were supported to take medicine only when required did not have clear protocols in place.

Peoples' care records and risk assessments did not consistently contain sufficient guidance for staff to follow.

People were supported by staff who made them feel safe. Staff understood their responsibilities to help safeguard people from abuse.

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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 quality of the service in respect of a one key question area.
After our previous comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the six breaches of regulation. We also met with the provider to discuss our concerns about the service and to hear about the improvements they planned to make.

We undertook a focused inspection of Proline Care Limited on 10 and 11 January 2017 to review whether people received a safe service. This inspection was conducted to assess whether improvements had been made to meet specific legal requirements, as planned and agreed to by the registered provider following our inspection on 4 and 18 October 2016. We inspected the service against one of the five key questions we ask about people's care: 'Is the service safe?' This inspection was announced and was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We asked the local authority and Health Watch if they had any information to share with us about the care provided by the service. As part of our inspection we also checked if the provider had sent us any notifications since our last visit. These are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths, safeguarding matters and injuries occurring to people receiving care. In addition we reviewed information the provider had sent us in response to our last inspection which outlined the action they planned to take to comply with regulations. This information helped us to plan our inspection. Following our inspection in October 2016, we spoke with the Local Authority who had visited the service to check the quality of care that people had received. The Local Authority advised us that they had found some concerns which resulted in the service being placed into voluntary suspension. This suspension of contract means that the local authority would not fund any new

people to receive a service from this provider.

During the inspection we met and spoke with the registered manager, the providers' representative, one care co-ordinator, one field supervisor, one senior care staff and 11 members of care staff. We spoke with 13 people who used the service and 12 relatives of people. We sampled records, including eight people's care plans, eight staff files and training records. We also sampled the providers systems for monitoring and improving the quality of the service.

Inspected but not rated

Is the service safe?

Our findings

At our last inspection on 4 and 18 October 2016 we identified a breach of regulation in respect of safe care and treatment, specifically issues related to medication management and management of risks. We also identified a breach of regulation in respect of staffing, specifically a lack of suitably skilled and competent staff in correct numbers to meet the needs of people. These were breaches of Regulation 12, and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the October 2016 inspection we found there was a risk that people were not getting their prescribed medication from staff. There were incomplete medication administration records and no assurance that people had been supported as agreed with medication they needed. People who only required medication as required (PRN) rather than at regular intervals were at risk of not receiving such medication consistently from staff. We also found that known risks to people's health and well-being was not consistently being met. We found that written risk assessments had not all been completed to ensure the potential risks to people and staff providing care and support were minimised. People were not consistently supported by the same staff which contributed to this risk. At that time we found that the provider had failed to ensure that enough suitably skilled and competent staff were deployed to meet people's care needs safely and appropriately as had been identified in individual care plans. Numerous people, their relatives and staff expressed their concerns in respect of poor staffing levels, in particular weekends. We also found that late and missed calls had been experienced by a number of people. Following that inspection the registered provider submitted an action plan indicating when the issues raised would be addressed. In line with the action plan submitted by the registered provider some improvements had been made and some actions had not yet been started or completely addressed.

At this inspection in January 2017 we found that some improvements had been made in management and recording of medication administered to people and further required improvements were planned. We found that medicine records were detailed and confirmed that people had been supported to take their prescribed medicines. A person who used the service told us, "They [the staff] check that I have taken my medication and put creams on me." We noted that carers applied prescribed creams to people's skin. Whilst on some people's records there was information available for staff on where and how often the creams should be applied this was not consistent for all the records we sampled.

We found that there continued to be no consistent approach to providing staff guidance in respect of the administration of 'as required' (PRN) medicines. Whilst there was no evidence that people had missed their (PRN) medicines; there was a risk that people might not receive the medicines consistently or that they would be given them at the wrong times. Following this inspection the registered provider sent us their updated action plan which advised of their intentions to ensure all PRN protocols were completed as required.

At this inspection we found that assessment of staff competency to administer medications safely had been improved. Most staff had received observational competency checks to ensure they were competent to administer medicines safely. A member of staff told us, "I have been observed giving medicines to people.

They [care co-ordinators] checked I had recorded everything, checked I had applied cream correctly and that I had washed my hands."

At this inspection the registered provider advised us that audits of safe medication management were due for completion at the end of January 2017 in line with their action plan. Prior to issuing this report information was received that the medicine audit had identified some of the shortfalls we had identified and action was being taken to address this issue.

At this inspection in January 2017 we found that risk management had improved but further improvement was needed. We saw that a number of people had been visited by the registered provider and most risks assessments had been reviewed and updated in line with people's changing needs. However, whilst the staff we spoke with knew about individual risks to peoples' health and well-being and how these were to be managed, we found peoples' care records and supporting documents did not consistently contain sufficient guidance for staff to follow. For example, we found on one person's risk assessment that a risk associated with their health condition was being managed in day to day practice. However it had not been identified in their records and records did not contain guidance for staff to follow. The registered provider advised us that they were continuing to review all the written risk assessments to ensure they were all accurate.

At this inspection we found that staffing availability and continuity of care for people had improved. Feedback from people using the service indicated that they were experiencing timely calls and people confirmed that they were mostly being supported by consistent staff. Further improvements were needed which the provider was addressing with the recruitment of new care staff. One person we spoke with said, "I have a consistent team now…It was terrible before….I was phoning them up…..I had different carers". Another person said, "Carers are on time, they are available when I need them. I can set my watch to them." We spoke with people and their relatives about the care and support they received at weekends and we received a mixed response. One person told us, "For the last few weekends I have had the same carers." Another person told us that they were really happy with their calls during the week but said, "The problems can be at weekends, especially Sunday evening as we don't always know who will come and they [the staff] come too late in the mornings." Most of the relatives spoke positively about the improvement of staff providing reliable and consistent care and support to their loved ones. One relative told us, "There have been no missed calls in the last 2-3 months." However, another relative told us that evening staff arrive too early for their relatives personal care needs and told us that some staff do not stay for the right duration. We shared these concerns with the registered provider who advised us that they would respond to the concerns identified.

Staff that we spoke with told us that staffing levels had improved but a number of staff informed us that weekend calls were still of concern. One staff member said, "Staffing levels have improved and staff are being recruited. Weekends are still a struggle." The registered provider informed us that recruitment was on-going with a focus on recruiting more staff available to work at weekends and said, "Having dedicated staff at weekends will give us more flexibility and availability to meet people's preferences and individual needs." We reviewed staff rotas and found that staff had been allocated travelling times between calls. One person told us, "Things weren't good but now they have improved 100%. The girls [staff] are very good and lately it has been the same team during the week as at weekends."

We found that staff recruitment practice had improved and the provider was continuing to make improvements and checking back on the records of existing staff to ensure that all the required checks and risk assessments were in place.

At this inspection we found that staff continued to be aware of their responsibilities to safeguard people

from potential harm. One member of staff told us, "If I saw abuse, I would reassure the person, report to my manager, or I could go to CQC [Care Quality Commission] or the Local Authority Safeguarding team." Discussions with the registered manager identified that any concerns or allegations about potential abuse had been promptly raised in-line with safeguarding procedures. This showed that any safeguarding matters would be investigated and people were protected.

Staff we spoke with confidently described the procedure for reporting accidents and incidents. One member of staff we spoke with told us, "Any accidents have to be reported and recorded. We saw that there had been an improvement in the recording and reporting of incidents. A member of staff said, "We all have incident log forms to use and have to report any incidents to the office straight away." We saw that accidents and incidents were analysed but they did not contain detailed outcomes to prevent the risk of them reoccurring .Staff we spoke with knew what emergency procedures to follow and knew who to contact in a variety of emergency situations. The service operated an out of hours on call system so that people, their relatives and staff had access to advice and assistance when the office was closed. One person said, "I have always got a response out of hours." A member of staff told us, "The on-call is much better managed now." Staff we spoke with told us they had undertaken training in emergency first aid. One staff member told us about an incident which involved an emergency and said, "I contacted 999 straight away and comforted [name of person] until they arrived." We noted that the registered provider was in the progress of updating their electronic training data base. This would alert the provider to when staff training required updating.

People spoke positively about the safety of the service. One person told us, "I ask for the same carers. I feel safe as I get anxious". Another person told us, "I feel safer now." Staff described the ways that they worked which ensured people were kept safe whilst not restricting their freedom. One member of staff said, "We make sure doors are securely locked when we leave and make sure electrics are turned off." Another member of staff told us, "It's important to make sure people can reach everything they need, like their personal alarms."