Patmark Gentle Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This was an unannounced focused inspection of Patmark Gentle Care Limited on 19 October 2017. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults and older people, supporting a range of needs including people living dementia, cancer, terminal illness, Parkinson, physical and mental health needs. At the time of the inspection 11 people were using the service.

Patmark Gentle Care Limited was registered with the Care Quality Commission 8 June 2017. To enable us to rate a service and answer the five questions is the service; safe, effective, caring, responsive and well led, we need at least six months. This allows for Patmark Gentle Care Limited to establish and embed their policies and procedures, and for us to gain an overview on how the service has been running / developing over a period of time. However due to concerns we received from the Commissioners of the service, and following a meeting with the provider's representatives on the 17 October 2017, we were not confidant that people were receiving a safe service. Therefore we carried out a focused inspection on 19 October 2017 to review two areas of the service; Safe and Well led.

During the inspection we found that the registered provider was in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager in post. 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.

We found that the provider was unable to demonstrate that they had robust systems in place to ensure people were receiving safe care and support. In addition their oversight and governance arrangements did not support the effective running of the service.

A breakdown in the working relationship and trust within the leadership team, had resulted in a blame culture, and impacted on their ability to put effective action in place. People were at risk of harm due to missed and/or late visits, untrained/inexperienced staff, unsafe recruitment processes and a failure to fully assess the risks related to people's complex needs.

As a result we took immediate urgent action to the provider regulated activity for three months, to give them an opportunity to make improvements and not placing people at risk from receiving inappropriate or unsafe care. Essex County Council have since supported all those using the service to move to an alternative provider. We will continue to review this service and the suspension.

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 safe.

Improvements were needed to ensure any risks to people, their safety and welfare were identified and acted on. This included appropriate staff skill and competency.

Is the service well-led?

Inspected but not rated

The service was not well-led.

Quality assurance, oversight and leadership of the service were not robust enough to independently pick up shortfalls and act on them. This put people at risk. The service was not being run safely.

Patmark Gentle Care Limited

Detailed findings

Background to this inspection

This inspection took place on 19 October 2017 and was unannounced. The service was registered on 8 June 2017. We reviewed information we had received since then about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public. The inspection was prompted following concerns raised by the Commissioners of the service which identified that people were not receiving a safe, quality service. This inspection examined those risks. It was undertaken by two inspectors.

We did not speak with any people who used the service directly, however we did receive feedback via local authority staff who had been completing reviews for six people using the service.

To help us assess how people's care needs were being met we reviewed three care records and other information, for example their risk assessments and medicines records.

We spoke with the registered manager and a Director / Owner of the service. We also spoke with four other members of staff. We looked at four staff personnel files and records relating to the management of the service. This included visit plans, training records, competency assessments, disciplinary records and Disclosure and Barring (DBS) checks.

Inspected but not rated

Is the service safe?

Our findings

Shortfalls in risk management, care planning, deployment of staff, staff skills, medicines and recruitment put people at risk of not receiving safe. This exposed people to the risk of harm because their individual safety, support and health needs were not being identified and / or acted on.

The service was not following safe recruitment practices. The provider was not always ensuring that they were in receipt of information, to ensure they were of good character, and safe to work with vulnerable people. Where the leadership had received information about staff, which could potential impact on them working with vulnerable people, there were no records to confirm that this had been taken into consideration, prior to staff commencing their employment. Not having safe recruitment systems in place put people at potential risk.

People's care records provided information on their physical, medical and mental health. However there was a lack of assessments providing clear information to support staff in taking prompt action to address / minimise risk. For example where a person was noted to be at risk of choking on 'food drink tablets', there was no further guidance on how to reduce the risk of this happening or what to do if it did happen. There was also a lack of information to manage potential health emergencies, to be able to provide effective support until professional help arrived. Staff were supporting people who had been identified as having falls, seizures or difficulty swallowing so knowing what to do in these events was critical.

The risk relating to untrained / inexperienced staff had not been assessed. For example the service's Statement of Purpose informed people using the service that 'All staff will be trained in moving and handling'. However records showed that not all staff had received this training. Records failed to show if staff knew how to use the equipment in people's homes safely so as not to place the person or themselves at risk of injury.

Information on the range of training provided did not reflect the service's Statement of Purpose states they are able to provide support and care for : Physical / mental health issues, terminally ill, cancer, dementia, Parkinson's and brain / spinal cord injuries. The risks associated with untrained or inexperienced staff providing care for people with complex needs had not been fully explored by the provider. For example a medication error occurred and it was established that the staff member responsible had no training. The risk of sending untrained staff to administer medicines should have been anticipated by the provider. This told us that medicines were not being managed safety.

Organisation of visits did not protect people from the risk harm due to missed or late calls. For example one person had a missed visit which impacted on their physical and emotional welfare. We saw that the planning was last minute as a Director of the service was completing the visit plans for the next day, during our inspection. One staff member had received a rota on 12 October 2017 at 11.30pm to inform them what visits they needed to complete for 13 October 2017. Another staff member had received a rota on 19 October 2017 at 6am for visits they had to complete on the same day of 19 October 2017 starting at 7.30am. This meant staff were not informed of their workload in an adequate amount of time for them to ensure against

missed and / or late calls to vulnerable and / or elderly people. In addition people receiving the service had little information about who would be attending and when.

During the inspection we saw that a call was received by the Registered Manager from a person who had not received a member of staff to carry out their care. The Registered Manager was unable to access the rotas to establish which member of staff should have been carrying out the call. The Registered Manager's only way of finding this information was to message to other staff. This meant we could not be assured that the running of the service was effective and safe for people.

Safeguarding guidance was not followed. Although inspectors were advised that the service was reporting safeguard incidents to the local authority it transpired this was not happening.

All of the above is was a breach of regulation 12 of The health and Social Care Act 2008 (Regulated Activities) regulations.

Inspected but not rated

Is the service well-led?

Our findings

The provider was unable to demonstrate that they had effective oversight of the service. The provider had appointed the registered manager to run the service. Having put this in place, they had not put in any other effective checks to monitor, support and to ensure good governance of the service. This resulted in a service having a lack of effective systems to ensure the quality and safety of the service. This included shortfalls in training, recruitment and governance and risk management.

The quality assurance checks that were in place were not robust enough. The registered manager and director had not independently picked up, and acted on risks. We were concerned that it was only when external agencies became involved that some action was prompted. However the response was limited in its ability make things better, with neither the registered manager, or the director effectively managing the risks in the interim or establishing an effective medium to long term plan.

The breakdown in the provider's organisational structure and responsibilities further impacted on the safety of people using the service. There was no effective contingency plan in place to ensure they had enough staff to meet the visits they had committed to. At the time of the inspection, the director was also covering care visits. This impacted on their ability to be in the office and have effective oversight. In addition the relationship between the director and the registered manager had broken down. This resulted in a lack of communication which meant neither knew what the other was doing. The registered manager told us that they were working their notice as they felt they could not effectively fulfil their role. Because of this situation we observed a blame culture which impacted on their ability to put effective action in place.

The leadership during this inspection had been unable to demonstrate that they had taken effective action to address the concerns raised by the Commissioner of the service, to reduce risk and ensure people's safety. We found that the provider had not taken effective action as a new service to ensure that their policies and procedures were sustained and embedded in practice. We had serious concerns that people will or may be exposed to the risk of harm.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of this inspection we took urgent action to suspend the regulated activity to ensure that people were not being placed at risk of harm. In addition the commissioners found alternative placements for all those receiving a service.

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 Shortfalls in risk management, care planning, deployment of staff, staff skills, medicines and recruitment put people at risk of not receiving safe. This exposed people to the risk of harm because their individual safety, support and health needs were not being identified and / or acted on. Regulation 12 (1) (2) (a) (b) (c) (e) (g)

The enforcement action we took:

Urgent Notice of Decision to suspend the regulated activity of personal care for three months.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance, oversight and leadership of the service were not robust enough to independently pick up shortfalls and act on them. This put people at risk. regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Urgent Notice of Decision to suspend the regulated activity of personal care for three months.