The Partnership Healthcare Group Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Partnership Healthcare Group Limited is a domiciliary care agency providing personal care to people in their own homes. At the time of our inspection there were 20 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive 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 the service and what we found:

The provider did not monitor the quality of care provided in order to drive improvements and ensure delivery of safe and good quality care. People had experienced missed and late calls, people's accidents and incidents were not monitored to reduce the likelihood of them happening again and people's care plans were not personalised.

Risks to people had not been fully assessed including risks associated with mobility, skin integrity, catheter care and health conditions. Medicines were not always managed safely. Not all people's medication administration records (MAR) detailed their prescribed medicines. There was a risk people did not receive their medicines as prescribed.

People and their relatives were not given the opportunity to provide feedback on the quality of the care provided. People and relatives told us communication from staff was poor. Not all staff felt supported by the provider, who is also the registered manager.

The provider had not ensured people were supported by staff who had the skills and knowledge to meet people's individual needs. The provider had not obtained satisfactory evidence of staff conduct in previous employment to ensure they were suitable in the role.

People were not always involved in planning their care. This meant people's care plans lacked information to help staff get to know people well. Mental capacity assessments were not always completed for decisions relating to people's care or treatment.

People told us they felt safe and that staff were kind and caring and respected their privacy and dignity. People were protected from the risk of infection. People were supported by staff to eat and drink well.

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

Rating at last inspection
The service was registered with us on 24 September 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the recruitment of staff and lack of communication from the provider. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to risk management, medicines and management and oversight.

We have taken enforcement action and cancelled the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

The Partnership Healthcare Group 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. 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
The inspection team consisted of 2 inspectors and 1 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 care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is

a small service and we needed to be sure that the provider and registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the local authority and professionals who work with the service. 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.

During the inspection
We spoke with 6 people and 6 relatives on the telephone about their experience of the care provided. We spoke with 10 members of staff including care staff, management staff and the provider, who is also the registered manager. We reviewed a range of records. This included 15 people's care records including care plans, risk assessments and medicines records. We looked at staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed including safeguarding and incident monitoring, auditing processes and staff training.

Inadequate

Is the service safe?

Our findings

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had failed to assess the risks to people using the service. We found risks to people had not been assessed and plans were not in place to mitigate risks including falls, skin integrity, catheter care, fire safety and medicines. This meant that staff did not have the necessary information to keep people safe which placed people at risk of avoidable harm.
- People who required support from staff for mobility needs did not have a detailed care plan to provide instructions to staff on how to support the person safely and how to mitigate any risks such as falling or injury. One person's care plan detailed they were high risk of falls and required support from staff to transfer into a motorised wheelchair. The provider had failed to complete a risk assessment and care plan to provide staff with the instructions on how to do this safely. This placed people at risk of receiving unsafe moving and handling support and significant harm from potential falls and injuries.
- The provider had failed to assess and mitigate risks to people needing support with catheter care. People were at risk of infections and urinary retention as there was no information to guide staff on the signs and symptoms of a catheter blockage or how to identify signs of a urinary tract infection.
- People were at increased risk of falls as the provider had not assessed people's home environments to mitigate potential risks such as trip hazards. One person had experienced multiple falls at home and their environment had been deemed by the care provider as cluttered. The provider had not assessed the person's home to ensure risks of falls were mitigated as much as reasonably possible.
- People were not always protected from the risks associated with their health conditions. For example, there was no care plans or risk assessments in place for people with diabetes. This meant staff did not have adequate guidance to identify or to know what action to take should the person experience too high or too low blood sugar levels. This placed people at risk of health deterioration.
- The provider had failed to review and thoroughly investigate accidents and incidents to make sure action was taken to prevent further occurrences and ensure improvements are made as a result. People experienced falls in their homes and the provider failed to complete a falls care plan or risk assessment to ensure risks were mitigated and managed to prevent a recurrence of the incident. People were at risk of continued accidents and incidents as the provider failed to have systems to learn from these.
- The provider failed to ensure staff providing care to people received training in pressure area care and skin integrity, diabetes awareness and catheter care to ensure they had the competence, skills and experience to do so safely. This alongside the lack of sufficient care planning and risk assessment placed people at exposed risk of significant harm.

Using medicines safely

- People were not always supported to receive their medicines safely.
- Medicine administration records (MAR) were not always kept up to date with people's prescribed medicines, which meant there was a risk to people not receiving their medicines as prescribed. For example, 1 person's care plan detailed a total of 6 medicines to be administered however, the MAR contained only 1 of those medicines. This has been incorrectly inputted onto the system by staff. This meant the person was at risk of harm and health deterioration through not getting their medicines as prescribed or by receiving incorrect doses of medicines.

● Prescribed creams were being applied to people with no MAR chart or guidance in place. Staff did not have information available to them to say where and how the cream should be applied. This meant people were at risk of having the cream applied to the incorrect area of the body, reducing the risk of effectiveness.
● Guidance was not in place for 'as required' medicines. This meant staff did not have the information and guidance available to them for when this medicine should be used or how to monitor the effectiveness. This placed people at risk of not receiving their medicines when required and according to the prescriber's instructions.

The provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People and relatives told us they felt safe when being supported by care staff. However, the provider did not have an effective system to identify, report and respond to safeguarding concerns.
● During the inspection we found evidence of staff not attending planned care calls to people and this not being identified by the management of the service. This placed people at risk of not receiving the care and support they required. As a result, CQC raised several safeguarding referrals with the local authority safeguarding team.
● We were not assured care staff always reported potential harm to people, despite having received safeguarding training. We found an incident in a person's daily records which should have been reported to the management team to assess and safeguard the person from potential risk of harm.

Staffing and recruitment
●Scheduling of care calls was not managed well and led to people experiencing late and missed calls. We received mixed feedback from people and relatives regarding the times of their care calls. One person said, "I have no idea of the times they [care staff] are supposed to come to me. Sometimes they arrive in the morning other times in the afternoon. The office never tell me who is coming or when." Another person told us, ""They [care staff] are usually on time, I have had no real problems although the office hasn't let me know if they are going to be late."
● The provider failed to obtain satisfactory evidence of staff conduct in previous employment to ensure they were suitable for the role. We have reported on this further in the well led section of this report.
● The provider completed Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection prevention and control practices.
● The provider ensured staff had completed training in infection prevention and control and staff had access to personal protective equipment (PPE).
● People told us staff washed their hands before supporting them.

Requires Improvement

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always assessed, care and support was not always delivered in line with current standards. People did not always achieve effective outcomes in relation to personal care.
- Not all people were involved in the assessment of their care and support needs. This meant people's care plans lacked sufficient detail on the care and support people required. One person told us, "I was not involved in the decisions as to what care I required and how many times they would call on me. I don't have a copy in the house either. No one has given me any real idea of what I should be getting." Another person's relative said, "The [care manager] came and talked through the plan with all mum's family members."
- The provider did not use evidence based, best practice guidance, such as NICE guidelines, to inform care plans and risk assessments. Care plans and risk assessments lacked detailed and did not always explore the full range of people's individual needs. For example, the provider had not carried out an assessment of risk for people at risk of developing skin damage or pressure ulcers due to their limited mobility. Care plans lacked insufficient instructions and measures for staff to follow to prevent people developing damage to their skin.

Staff support: induction, training, skills and experience

- Staff training required further development to ensure staff had the skills and knowledge needed to meet people's individual care and support needs. A relative told us, "Initially they [care staff] struggled but now they are fine with [person's] guidance." A person said, "Some are good others don't seem to know what they need to do."
- The provider was unable to evidence that they were regularly supporting staff through supervisions and spot checks . This meant, staff did not have a formal process to review their workload, monitor and review performance, and identify any learning and development opportunities. One staff member said, "No one has come in my presence to check whether clients have been given medications properly or not."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not have care plans for specific health conditions. For example, 1 person's care plan detailed they had a medical history of epilepsy. There was no further information within the care plan regarding this. This meant there was no guidance available for staff on how the condition affected them, signs and symptoms that may indicate a decline in health, what actions to take or when to seek support from healthcare professionals.
- The service had a limited role in supporting people to access healthcare as people's families were

involved in their care or people managed this themselves. However, staff made contact with healthcare services if required. A relative said, "Every now and again [person] gets a urinary tract infection so the carer contacts the manager who gets in touch with the GP to do tests and prescribe anti-biotics."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● The provider was not always working in line with the Mental Capacity Act. Where people were deemed to lack capacity to make a specific decision about their personal care, formal assessments had not been carried out to assess whether they needed support with decision making. This meant staff had no guidance in place, and risked staff restricting people by making unlawful decisions on their behalf.
● People and their relatives told us staff sought consent prior to providing care and support. One person said, "They [care staff] do ask for my consent before doing anything and if I ask them to do something they will."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet. One person said, "They [care staff] ensure I always have plenty to drink." One person's relative told us, "The carers give [Person] her breakfast and help prepare her meals doing her tea of an evening."
● Staff had received training in nutrition and fluid awareness and staff we spoke with explained the support they provided to people. One staff member said, "Most of my clients are independent and they have their food by themselves. But I always encourage them to eat healthy food."

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always well treated and supported. Care plans contained basic details about people and lacked information to help staff get to know people well, including people's preferences, personal histories, and backgrounds.
- There was mixed feedback from people and relatives about continuity of care enabling them to build caring and trusting relationships with staff. One person said, ""It is hard for them to get to know my likes and dislikes because the carers change so much." A relative told us, "When [person] had regular carers she could bond with them but has too many different carers now."
- People and their relatives told us care staff were kind. One person said, "The girls are very kind to me, they listen to me and are very patient with me."

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to express their views and make decisions about their care as not all people were involved in the assessment and planning of their care. One person told us, "I was involved in the assessment of my care needs and I got what I felt I required. They told me I could make any changes if necessary but currently I am happy with the package I have currently." Another person said, "I was not involved in the decisions as to what care I required and how many times they would call on me. I don't have a copy in the house either. No one has given me any real idea of what I should be getting."
- The provider was unable to demonstrate systems were in place to seek views about the quality of the service from people, or their relatives. One person said, "I have no idea who the manager is, and I have not had any contact with them."

Respecting and promoting people's privacy, dignity and independence
- People's privacy, dignity and independence was respected and promoted.
- One person said, "The carers do encourage me to do things myself. I am deaf and they are tolerant with me when they have to repeat themselves."
- One person told us, "The carers are very good when it comes to my privacy. They ensure blinds are closed so no one can see in when helping me with my personal care."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not personalised. People were not always supported as individuals, or in line with their needs and preferences.
- Not all people's care plans contained personalised and important information such as culture, religion, staff gender preference, likes and dislikes, end of life decisions and oral care support. This was due to the provider not making contact with all people and/or their relatives to gain further information about people and to learn about them as individuals. Information in people's care plans was mainly taken from information provided by the local authority commissioners.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure in place however, information about how to complain had not been shared with all people in receipt of personal care and their relatives. This meant we could not be assured people knew how to raise a complaint.
- People's relatives told us where they had reported a concern or complaint to staff regarding people's personal care support, action had been taken and things had improved as a result.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were understood and supported. For example, 1 person's care plan detailed they required written information to be provided in a larger font due to being partially sighted.
- The provider understood the Accessible Information Standard and was able to make information available to people in different formats such as easy read.

End of life care and support

- At the time of the inspection, no one was receiving end of life care.
- People's care plans did not include information around people's end of life wishes and decisions such as who they would like to be with them during that time and any funeral arrangements. We could not evidence people had been given the opportunity to have those discussions as this was not detailed within people's care records.

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.

This is the first inspection of this newly registered service. This key question has been inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider, who was also the registered manager, failed to monitor the quality of care provided in order to drive improvements and ensure delivery of safe and good quality care.
- There were ineffective governance and auditing systems to assess, monitor and mitigate the risks to people. During the inspection we identified missing or incomplete risk assessments for risks relating to pressure care, fire safety and moving and handling. This had not been identified through the providers quality assurance systems and placed people at potential risk of harm.
- The provider had failed to create a learning culture at the service, which meant people's care was not improved. There was no process in place to monitor accidents and incidents to identify themes, trends and learn lessons to reduce the likelihood of them happening again.
- People experienced missed and late calls due to the provider having ineffective systems to oversee and monitor care call compliance to ensure people received their planned care calls. We reviewed records from July 2023 and found 102 unlogged calls. The provider could not evidence those call visits had taken place as required to meet people's care and support needs. This had not been identified through the provider's quality assurance systems.
- The provider failed to have a system in place to provide person-centred care that achieved good outcomes for people. There were ineffective governance and auditing systems to review and update people's care plans to ensure staff had clear and current guidance on how to support people in a way that was personalised, met their needs and kept them safe.
- The provider failed to have systems and processes in place to check safe recruitment procedures were followed as per their policies and procedures. We reviewed staff recruitment files and found limited evidence of sufficient references being obtained to ensure staff were suitable for the role. This placed people at risk of receiving care from staff that had not been proven to be of good character or suitably skilled for the role.

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

- The provider failed to implement systems to actively encouraged feedback from people and their relatives about the quality of care people received. The provider was unable to demonstrate an understanding of equality characteristics and had not actively encouraged feedback from people and their relatives about the quality of care people received. A person told us, ""I have no idea who the managers are. I don't think I have

ever seen or spoken to one. I can only imagine the company is fairly well managed but I am not confident that the managers know exactly what care I require or get as I don't know myself."
● People and their relatives said the communication they received was poor. One relative said, "Over the last 3 weeks they [care staff] haven't turned up 4 times without letting us know." A person told us, "No one contacted me to let me know they'd [care staff] be late."
● Staff did not always feel supported by the provider and management team. One staff member said, "Every day I call them but they don't answer my phone and they don't even reply." Another staff member told us, "I feel like at first we [care staff] were really supported but as of now, I don't feel like I am supported."
● Staff did not have the opportunity to engage and share learning or areas of improvement with the provider and registered manager as they had not been in receipt of regular supervision and/or team meetings. Feedback from staff confirmed this.

The provider had failed to operate effective systems and processes and provide consistent and effective leadership to assess, monitor and improve the quality and safety of the services provided. This is a breach of Regulation 17 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 provider understood their responsibilities under the duty of candour. However, they had failed to act upon this duty when things went wrong, such as when people had experienced missed care visits. For example, 1 person's call was missed due to a miss communication between the staff team which led to the person contacting emergency services for support. We did not see evidence that duty of candour was followed for this incident.

Working in partnership with others
●The provider did not always work in partnership with others. CQC and other professionals found communication with the service challenging and at times and had no response from the provider to emails and telephone calls.

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 The provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely.

The enforcement action we took:

We cancelled the provider's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess the risks to the health and safety of people using the service, manage medicines safely and ensure staff had the skills and competence to support people safely.

The enforcement action we took:

We cancelled the provider's registration