Precious Passionate Care Ltd

Precious Passionate Care Ltd

Inspection report

Princess Works, Birds Royd Lane
Princess Street
Brighouse
West Yorkshire
HD6 1LH

Tel: 01422350279
Website: www.preciouspassionatecare.co.uk

Date of inspection visit:
19 October 2022
31 October 2022
08 November 2022

Date of publication:
13 January 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Precious Passionate Care Ltd is a domiciliary care agency providing personal care to people in their own homes. 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. At the time of our inspection there were 64 people receiving personal care.

People's experience of using this service and what we found
People were not always safe. People, relatives and staff said the service had deteriorated in recent months and communication was poor. People's care needs were not always met as staff were not deployed effectively. People and their relatives told us care calls were often late or missed and staff did not stay the full duration of the call. People said sometimes staff were sent who did not know how to meet their needs.

People were at risk of harm as the provider had not identified, assessed or mitigated risks. Safeguarding incidents were not always identified and acted upon appropriately or promptly. Medicines were not managed safely.

Care records did not reflect people's needs and were not always clear about the care to be provided on each call. People and their relatives said they were unable to access their care records.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level. Quality assurance systems were not implemented.

People and their relatives said the staff were nice, friendly and chatty. Staff were recruited safely and safe infection control procedures were followed.

The nominated individual told us action would be taken to address the concerns we identified at this inspection.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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 21 November 2018).

Why we inspected
We received concerns in relation to the management of the service, staffing and meeting people's care needs. 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 inadequate 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 Passionate 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 have identified breaches in relation to safe care and treatment, staffing, safeguarding and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Precious Passionate 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
The inspection was carried out by 3 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 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.

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 unannounced. Inspection activity started on 18 October 2022 and ended on 8 November 2022. We visited the location's office on 18 October 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and 9 relatives about their experience of the care provided. We spoke with 6 staff including the registered manager, the administration manager and care staff. We reviewed a range of records. This included 5 people's care records. We looked at 3 staff recruitment files and a variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely which placed people at risk of harm.
- People were not receiving their medicines as prescribed. Two people had not received their pain relief patches. One person's medicines were shown as 'not available'' or 'not required' with no further explanation. Safeguarding referrals showed missed calls where people had not received their medicines.
- Daily records showed staff had administered medicines to 1 person, yet there was no record to show what medicines had been given and no medicine care plan.
- Daily records showed staff were applying creams to people. However, there were not always records or body maps to show which creams were being used, where they should be applied or how often. One person's cream had not been applied as prescribed and records showed the soreness of their skin had increased.
- Staff said medicines guidance was not always clear or correct.
- There was limited guidance available to care staff about 'as required' medicines.

Systems were either not in place or robust enough to demonstrate medicines were 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.

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

- Risks to people were not assessed or managed safely placing them at potential risk of harm.
- People's care records did not always include individual risk assessments. For example, there was no moving and handling assessment or falls risk assessment for a person who used a walking frame, had a visual impairment and was at risk of falls.
- Environmental risk assessments had not always been completed.
- Incidents were not consistently recorded or acted on. Feedback from people showed incidents had occurred. There was no information to show the action taken to mitigate risks and protect people from further incidents occurring.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People's needs were not met as staff were not deployed effectively.

● The registered manager, who was also the responsible individual, told us the call monitoring system was not linked to the electronic system the care staff used. They said this meant if a staff member had not signed into or out of a call or left the call early the office staff and managers were not alerted.
● People and relatives said the service had deteriorated in recent months. They spoke of missed and late calls, staff not always staying the full duration of the call and not enough staff turning up. Comments included; "'I had a missed call on Saturday. No phone call. I phoned them and they said it was due to a family emergency. No one came"; "Time keeping has deteriorated since the middle of September. Before then it was fine. No concerns. Now its abysmal"; "[Call times] good in the past. Erratic at the moment. They never let me know when they are coming. I don't bother to ring anymore. I just wait" and "Some [staff] stay allocated time, some don't" and "Two [care staff] are supposed to start at the same time. But one turns up and the other is perhaps 20 - 30 minutes late."
● People and relatives said sometimes staff were sent who did not know the person's needs or the support they required. Comments included: "New staff who have never been here ask me what to do" and "My care needs are met when my regular [care worker] is here. It goes to pot when she isn't. [Care staff] don't know what to do."
● People, relatives and staff raised concerns about out of hours support and communication. This included phone calls going unanswered and no response to messages left.

Systems were either not in place or robust enough to ensure staff arrived on time and stayed the full duration of the call. This placed people at risk of not receiving the care they required. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed calls were now being scheduled and monitored by management. They confirmed weekly rotas were being sent to people so they knew which staff would be attending the calls.

● Recruitment processes were safe with all required checks completed before new staff started employment.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse.
● Safeguarding incidents were not properly managed, recorded and investigated.
● There was often a delay in safeguarding referrals being made to the local authority and CQC were not notified of safeguarding incidents.
● One person told us of a serious incident that had occurred with a care worker. This had not been recorded. There was no evidence of any investigation and the incident had not been referred to safeguarding by the provider.

The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff said they had received training in infection control and personal protective equipment (PPE). They confirmed they were provided with adequate supplies of PPE.
● People and relatives told us staff were using PPE effectively and safely.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; 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

- People did not receive a service that was well-led. Significant shortfalls were identified at this inspection. Regulatory breaches were identified in relation to safe care and treatment, staffing and safeguarding. These issues had not been identified or addressed through the provider's own governance systems.
- Following the first day of our inspection we informed the nominated individual of our concerns and requested a response detailing the action they would take to ensure people were safe. We did not receive a response. We made referrals to the local authority safeguarding team.
- There was a lack of effective management and leadership. The lack of management oversight had contributed to the shortfalls identified.
- People, relatives and staff said management and organisation of the service had deteriorated in recent months and this had impacted negatively on the care people received.
- Quality assurance systems had lapsed. The registered manager confirmed there were no medicine audits and, although we requested evidence of other quality audits, none were provided.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. The system used for staff to log in and out of calls and record their notes was not monitored effectively. Records we reviewed were incomplete or lacked detail and there were no audits. This meant there were no assurances staff attended the calls on time or for the correct length of time.
- Care records were not always accurate, did not reflect people's needs and were not always clear about what care was to be provided on each call.
- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. During this inspection, we found the registered person did not ensure CQC was consistently notified of reportable events. This meant we could not check appropriate action had been taken to ensure people were safe at that time.

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

- People and relatives spoke positively about the care staff. Comments included; "[Care staff] on the whole are pretty good" and "[Care staff are] very friendly, very nice and chatty."

● People and relatives said they would not recommend the service at this time and felt communication had deteriorated. They described not being able to get through to the office or managers and being put on hold. Comments included; "Poor when you do contact them. You don't get very far" and "Previously they would always resolve things. It doesn't feel the same process now. Communication's poor."
● People and relatives said they had no access to their care records since a new computerised system had been implemented. The provider advised they were processing requests to access the system in accordance with data protection legislation.
● Staff said communication was poor and on call arrangements were not clear. They said the new computerised care system went live before staff had completed their training in how to use the system.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed people and their relatives now had access to their computerised care records. They confirmed action had been taken to ensure staff were trained in the computerised system and improved communication.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals.

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 Medicines were not managed safely and risks to people were not assessed, monitored and mitigated. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to protect people from abuse and improper treatment. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective processes were not in place to assess, monitor and mitigate risks to people, to assess, monitor and improve the quality of the service and to maintain accurate and contemporaneous care and treatment records. Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively to meet people's needs and keep them safe. Regulation 18 (1) (2)