PHC Home Care Limited

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Inspection report

Systems House
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Harrow
Middlesex
HA2 7HJ

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

PHC Home Care Limited 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 older adults living in the London borough of Harrow.

At our previous inspection in April 2018 we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to risk assessments, staff training, care plans and quality monitoring. The provider was placed in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During our comprehensive inspection in April 2018, the service demonstrated to us that improvements had been made. The service is no longer rated as Inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The service has a registered manager. 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 risk assessments were now in place for a range of identified risks including moving and handling, skin care, eating and drinking, medicines and environmental safety. These provided information for care workers on actions to be taken to reduce the risk of harm.

The service now had sufficient numbers of care workers to be deployed to meet people's needs. However, a few people still reported late or missed calls. Care workers confirmed to us that they were undertaking all calls as assigned. We looked at staffing rotas which the registered manager told us were provided to care workers on a weekly basis. These showed that people were supported by the same care workers wherever possible.

Improvements had been made in safeguarding people. There was a safeguarding policy and procedure in place. Care workers could tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, the local authority or Care Quality Commission (CQC).

Safe recruitment procedures were now in place. This ensured all pre-employment requirements were completed before new staff were appointed and commenced their employment. At least two references were in place for all care workers. A Disclosure and Barring Service (DBS) check had been completed prior to staff commencing work.

The system for monitoring calls had not been developed further since our last inspection. We found that the registered manager continued not to have oversight of missed calls. We found the monitoring system to be

ineffective as no late or missed calls had been recorded even though we had been notified by people of recent occurrences.

People's needs had been assessed by the service prior to receiving services. Care plans included guidance about meeting these needs. However, some people had missed calls, which meant they may not have received care that met their needs.

The service monitored people's health and when it was necessary health care professionals, like doctors and district nurses were involved to make sure people were supported to remain as healthy as possible. However, in some examples we found that people who had significant weight variations had not been referred to specialists.

Staff had now completed essential training. Future training and refresher courses had been scheduled for 2019. New care workers had completed an induction using the Care Certificate framework before commencing work. They had received supervision, which included one-to-one meetings and work based observations (spot checks).

The requirements of the Mental Capacity Act (MCA) 2005 were met. People were involved in making decisions about their care and support. People had signed their plans to show that they consented to the care provided by the service.

The feedback we received from people concerning care workers was mostly positive. However, the concerns we found at this inspection did not demonstrate a caring approach. Some people still reported late calls and these were not recorded or analysed, which meant there was not system for ensuring improvements were carried out.

People's care plans were now detailed and gave an account of people's needs and actions required to support them. The care plans we reviewed were up to date and contained information about the support that people required. However, we found a record of an incident that demonstrated that a care worker may not have followed care plan guidance while delivering care.

Since our last inspection in April 2018, the registered manager had introduced systems and processes to improve on their governance systems. However, the service could not demonstrate significant improvements. The service still did not maintain accurate, complete and contemporaneous records relating to care delivery. The system for recording complaints or issues was also ineffective. No complaints had been recorded at the service, even though people and their relatives had spoken about concerns.

The provider has still not taken all reasonable steps to ensure that they are financial viable to continue to support people.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and a breach under Regulation 13(1) of the Care Quality Commission (Registration) Regulations 2009 (the 2009 Regulations). You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

We found that further improvements were required.

Risks assessments were now in place for a range of identified risks. However, no action had been taken in relation to identified risks which could have had a negative impact on people's health and mobility.

The service was still not learning and making improvements when things went wrong. Calls were not being checked on a routine basis to make sure they were completed.

The service now had clear systems to keep people safe and safeguarded from abuse. New care workers had now received training in safeguarding adults at risk. However, we found out that an incident had not been reported to the management.

Safe recruitment procedures were now in place. This ensured all pre-employment requirements were completed before new staff were appointed and commenced their employment.

Is the service effective?

Requires Improvement

The service was not effective.

Further improvements were required.

Although people's needs had been assessed by the service, their needs were not always met. Some people still reported missed calls.

The service monitored people's health and when it was necessary health care professionals were involved. However, in some examples we found that people who had significant weight variations had not been referred to specialists.

Care workers had now received training before commencing

work with people.

Consent was sought in line with the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives told us staff were kind and caring. However, the concerns we found at this inspection did not demonstrate a caring approach.

Care workers understood the need to protect people's dignity. They told us they closed doors when attending to people's care.

Care plans contained information so that care workers could understand people's preferences. We saw that the service matched care workers according to people's interests.

Is the service responsive?

Requires Improvement

The service was not responsive.

Further improvements were required.

Care plans now included information relevant to people's care and support.

Some people receiving care confirmed to us that us that they had experienced some missed calls. Therefore, people's needs may not have been met consistently

The system for recording complaints or issues remained ineffective. No complaints had been recorded at the service, even though people and their relatives had spoken about concerns.

Is the service well-led?

Requires Improvement

The service was not well led.

Further improvements were required.

The provider did not effectively assess, monitor and improve the quality and safety of the service provided.

The provider has still not taken all reasonable steps to ensure that they were financially viable to continue to support people.	

PHC Home Care Limited

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 overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 5 and 7 December 2018. The inspection was carried out by two inspectors, and an Expert by Experience (ExE) who had experience of care services for older people and people living with dementia. An EXE is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed information we held about the service, including notifications, previous inspection reports, the provider's recovery plan, safeguarding and quality assurance reports and feedback from the host local authority. A notification is information about specific events, which the service is required to send us by law.

We spoke with the registered manager, nominated individual and seven care workers. We looked at 12 records for people receiving care from PHC Home Care Limited. We also looked at the personnel records for seven care workers, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, in April 2018, we found that the provider was in breach of Regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no clear systems to keep people safe and safeguarded from abuse and the service did not have sufficient numbers of care workers to meet people's needs. We rated the provider as 'inadequate' under the key question of 'Is the service safe'. At this inspection we found the provider had made improvements. However, improvements were still required.

We looked to see how risks to people were assessed so they were supported to stay safe. We found that risk assessments were now in place for a range of identified risks including moving and handling, skin care, eating and drinking, medicines and environmental safety. These provided information for care workers on actions to be taken to reduce the risk of harm.

The service had also undertaken MUST (Malnutrition Universal Screening Tool) assessments on some people whose weights were regularly recorded. However, the service had not acted when concerns were found. For example, one person's weight chart showed that their BMI (body mass index) had increased from 27 (overweight) to 32 (obese) over a period of three months. The chart noted, "BMI increased. Eating and drinking well." However, no action had been taken in relation to this significant weight gain which could have had a negative impact on the person's health and mobility. We found two similar examples where significant changes in people's weight had not been followed up.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2018 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not have clear systems to keep people safe and safeguarded from abuse. We also found that some care workers had not received training in safeguarding adults at risk. At this inspection we found that improvements had been made. There was a safeguarding policy and procedure in place. Care workers could tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, the local authority or Care Quality Commission (CQC).

Care workers confirmed that they had received training in safeguarding. However, we saw that in one incident procedures had not been followed. This related to an incident that was reported to us by one person receiving care. The person told us that they had sustained an injury whilst receiving care from a care worker. We found out that this incident had not been reported to the management. We spoke with a care worker who confirmed the incident had occurred but had not reported it. We acted to refer this to local safeguarding team, who responded and advised that the incident did not constitute safeguarding. However, further improvements were still required in ensuring care workers consistently followed policies and procedures.

At our previous inspection, the service had failed to carry out adequate checks of the suitability of staff members prior to their employment. References and criminal records checks (DBS) had not always been obtained. We also found that the service had not addressed concerns relating to two care workers, who had previous convictions noted on Disclosure and Barring Service (DBS) checks. The service had not undertaken any risk assessment to establish if the care workers posed any on-going risk to the people who used the service. At this inspection we found safe recruitment procedures were now in place. This ensured all pre-employment requirements were completed before new staff were appointed and commenced their employment. At least two references were in place for all care workers. A Disclosure and Barring Service (DBS) check had been completed prior to staff commencing work.

In our previous inspection, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service did not have sufficient staff to meet people's needs. Some care workers had terminated their employment owing to unpaid wages. As a result, a significant number of people had experienced late or missed calls. At this inspection we checked to see how late or missed visits were recorded and analysed to prevent similar incidents from occurring.

We received mixed feedback from people regarding staff punctuality. One person told us, "The service does not have enough staff. The care workers keep coming and going." This person went on to explain that they had experienced a few missed calls in November 2018, citing weekends as the time where most missed calls had occurred. Another said, "Care workers arrive on time. They let me know if they are running late."

We looked at staffing rotas which the registered manager told us were provided to care workers on a weekly basis. These showed that people were supported by the same care workers wherever possible. At the time of the inspection the service employed 13 care workers. The care workers confirmed to us that they were undertaking all calls as assigned.

However, as in the previous inspection, the service had not implemented a system for monitoring calls. We asked about the system for monitoring that calls had taken place. The service used an electronic call system which was intended to log and monitor all care calls made by care workers. We looked at the call log for the system on the afternoon of 7 December 2018. We saw that care workers had not logged at least five calls that were due to have taken place that morning. We asked the nominated individual how the service ensured that these calls had been undertaken. They told us that, if care workers couldn't log into the electronic system they would text the service to advise that they had arrived at the person's home. We asked the nominated individual to check whether text messages had been received for three of these unlogged calls. We found that no such texts had been forwarded by staff. We discussed this failure with the nominated individual. They told us that they would ensure that the importance of logging all care calls was discussed with staff.

The nominated individual confirmed that there was no formal process for using the electronic system for checking that care calls had actually taken place. They told us that they relied on people using the service to contact the office and advise them if a care worker had not arrived at the expected time. We looked at people's daily care records which were completed by a care worker at each care visit. We found that there were gaps in these records for three people. The registered manager told us that they had identified concerns with staff record keeping and were planning to undertake training in relation to this. However, we found that there was no evidence that the provider had reviewed these records when they were brought into the office as part of the call monitoring process nor of any actions taken in relation to unrecorded care calls.

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

The service's records of accidents and incidents showed that two incidents had been recorded since our last inspection. These were both related to issues found when checking prescribed medicines received from a pharmacist. The records showed that appropriate action had been taken by staff.

There were systems in place to ensure proper and safe use of medicines. Care workers had received medicines training. There was evidence they had been trained and assessed as competent to support people to take their medicines. There was a medicines policy which provided guidance in line with national guidance from the National Institute for Clinical Excellence (NICE). We reviewed MAR charts and were completed with no gaps. There was a record showing that monitoring of medicines records had commenced on 30 November 2018.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, in April 2018, we found that the provider was in breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found out that staff had not received the training and support that they needed to ensure that they were competent in their roles. We rated the provider as 'requires improvement' under the key question of 'Is the service effective'. At this inspection we found the provider had made improvements. However, further improvements were required.

People's needs had been assessed by the service prior to receiving services. Assessments covered areas such as nutrition, moving and handling, communication, health and safety, and relevant medical conditions. Care plans included guidance about meeting these needs. However, some people had missed calls, which meant they may not have received care that met their needs.

We saw evidence that the service monitored people's health. When it was necessary health care professionals, like doctors and district nurses were involved to make sure people were supported to remain as healthy as possible. People were referred to relevant health professionals when they were unwell and/or needed specialist care and treatment. However, some examples we found that people who had significant weight variations had not been referred to specialists. No explanation was given for not undertaking this.

People told us care workers were available to make sure they had enough to eat and drink. In some examples people's relatives prepared their meals. However, where required, care workers supported people to prepare and eat their meals. There was a nutrition and hydration policy to provide guidance to staff on meeting the dietary needs of people.

Care workers had completed an induction using the Care Certificate framework before commencing work. The Care Certificate is a method of inducting care staff in the fundamental skills and knowledge expected within a care environment. Care workers had completed their induction and we saw that new care workers were enrolled on the programme.

We reviewed training records and we saw that care workers had completed essential training. Future training and refresher courses had been scheduled for 2019. Training included health and safety, infection control, safeguarding, manual handling and medicines management. There were systems and processes in place to support care workers. They received supervision, which included one-to-one meetings and work based observations [spot checks]. Care workers told us supervisions provided an opportunity to discuss working practices and identify any training needs. Care workers confirmed new care workers 'shadowed' more experienced care workers prior to working with people.

The requirements of the Mental Capacity Act (MCA) 2005 were met. The MCA 2005 provides a legal framework for making particular 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 particular 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 when this is in their best interest and legally authorised under the MCA.

People were involved in making decisions about their care and support. People had signed their plans to show that they consented to the care provided by the service. The care plans included guidance for care workers around seeking consent to care tasks and ensuring that people were enabled to make meaningful choices about how their care and support was provided.

People's choices were recorded in care plans. There was a record of people's preferences and requirements in relation to a range of areas including eating and drinking and personal care. People's care plans reminded staff to ensure that relevant procedures were explained to people and consent obtained before carrying out care.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in April 2018, we rated the provider as 'requires improvement' under the key question of 'Is the service caring?'. At this inspection we found the provider still required improvement.

People receiving care told us that their dignity was respected. A relative of a person receiving care told us the managers of the service did not always show empathy, citing their failure to respond to their loved one's health needs.

The feedback we received from people concerning care workers was mostly positive. However, the concerns we found at this inspection raised concerns about caring. For example, some people still reported late calls and these were not recorded or analysed, which meant there was no system for ensuring improvements were carried out.

At the previous inspection we found that care workers had not received sufficient training and support to ensure that they were competent in their roles. At this inspection we found that they had received essential training to enable them to care for people. They understood the need to protect people's dignity, values, beliefs and culture. They told us that they maintained people's privacy and dignity by ensuring they addressed them by their preferred names. They closed doors when attending to people's care. In examples where care workers kept keys, they still knocked on people's doors.

The service ensured people's personal information was stored securely in locked cabinets. Care workers were aware that before people's confidential information could be shared with others, they were required to seek consent from people. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the new General Data Protection Regulation (GDPR) law, which came into effect on 25 May 2018.

Care plans contained information so that care workers could understand people's preferences. We saw that the service matched care workers according to people's interests. Care workers were matched according to age, language, hobbies and religion. As such, rotas were organised so that people received care, as much as possible, from regular care workers. In other examples people with high needs were attended to by experienced staff. The registered manager, attended to people with complex needs.

People were supported to maintain their independence. Their care records contained information about their choices and independence. Care workers knew each person's ability to undertake tasks related to their daily living. Care workers were encouraged to take time to support people to participate as fully as they could. People told us that they were encouraged to be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, in April 2018, we found that the provider was in breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not detailed enough to provide care workers with sufficient guidance to support people. At this inspection we found that improvements had been made. However, we identified further areas of practice that needed improvement.

People's care plans gave a detailed account of people's needs and actions required to support them. The care plans we reviewed were up to date and contained information about the support that people required. People's likes and dislikes were highlighted. The care plans included guidance for care workers on how people preferred to be supported and communicated with. People's care assessments had been reviewed and updated. These now included information about their personal needs, histories and preferences. The information contained in people's care plans corresponded with their care assessments. However, we found a record of an incident that demonstrated that a care worker may not have followed a care plan guidance while delivering care.

Some people receiving care confirmed to us that us that they had experienced some missed calls. This meant that they had not received care as planned. Care workers were required to complete a log of the actions they had taken to support people at each care visit. When we looked at recent care logs we found that there were gaps in the records for some people. For example, for a person requiring three daily care visits, only one visit was recorded on three consecutive days in November 2018. The records for another person requiring three daily calls, showed that only one or two calls were recorded on five days during the same month. Therefore, people's needs may not have been met consistently.

We looked at how the service complied with the Accessible Information Standard (AIS). The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The care records contained information relating to people's communication needs. This ensured care workers had information they required to effectively communicate with people.

People told us that they were aware of the complains procedure. A complaints procedure was shared with people as part of their support package. A relative of a person receiving care told us that they had made a complaint to the service regarding the care their loved one was receiving. However, the complaints record maintained by the service showed that no complaints had been recorded since our previous inspection of April 2018. It was not clear if the complaint was formal or informal. Nevertheless, this complaint had not been recorded. Therefore, we were not able to evidence that the service had dealt with the complaint appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, in April 2018, we found that the provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes were not operating effectively to monitor and improve the quality of the service. We rated the provider as 'inadequate' under the key question of 'Is the service well-led'. At this inspection we found that further improvements were required.

Since our last inspection in April 2018, the registered manager had introduced processes to improve on their governance systems. However, the service could not demonstrate significant improvements. Whist we saw that an audit of care files had taken place in November 2018, audits in other key areas such as people's daily care logs, were not completed. The registered manager told us that the service had not started other audits as she was concentrating on ensuring that people's care plans and risk assessments were up to date. However, this had been outstanding from our two previous inspections, January and April 2018.

Furthermore, we also saw that the system for monitoring calls had not been developed further since our last inspection. We found that the registered manager continued not to have oversight of missed calls. We found the monitoring system to be ineffective as no late or missed calls had been recorded even though we had been notified by people of recent occurrences.

The provider did not always maintain accurate, complete and contemporaneous records relating to care delivery. We still found gaps in people's daily care logs. This demonstrated the provider was not working in accordance to their policy. Therefore, there was a risk that people would receive care and treatment which was not appropriate and meeting their needs.

The system for recording complaints or issues was also ineffective. No complaints had been recorded at the service, even though people and their relatives had spoken about concerns. The complaints records maintained by the service showed that no complaints had been recorded since our previous inspection of April 2018.

The above evidence shows a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2018 we found a breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 13. This is because we were not assured that the provider had a clear financial arrangement in place or that the arrangements to address the financial situation were viable or transparent. There was a risk that the provider would not be able to meet their financial commitments and therefore not be able to provide care to people.

At this inspection we found that the arrangements to address the financial situation were still not viable and transparent. We found that the provider did not have all the relevant financial information in place. Subsequently, we requested for the information to be sent to us following the inspection. We have since

requested for the financial information from the provider on several occasions to evidence their financial viability but the information provided so far remains vague, imprecise and incomplete.

Therefore, the provider remains in breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 13.