Our Care Ltd

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Inspection report

The Saturn Centre, Spring Road
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Wolverhampton
West Midlands
WV4 6JX

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
Our Care Ltd is a domiciliary care service that provides personal care to people living in Wolverhampton and surrounding areas. 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 visit, the service was providing person care support to approximately 26 people, some of whom were living with dementia.

People's experience of using this service and what we found
The provider had not ensured that staff followed safe systems and recorded the support they had given to people with their medicines. Risk management plans were not always detailed or reviewed consistently to ensure staff had the guidance they needed to support people safely.

The provider's systems had not ensured that people always received a reliable, consistent service. Care calls were not always planned to allow travelling time, which meant staff frequently ran late and people sometimes felt their care was rushed, which compromised their dignity.

There was a lack of oversight of the service. The service had grown rapidly in a short space of time and the provider was not effectively monitoring the quality and safety of the service. People and relatives knew how to complain but did not always feel confident their concerns would be listened to or acted on. The provider had systems to gather feedback on how the service could be improved but could not demonstrate that these were being effectively operated and people's views acted on.

People had good relationships with the staff they saw on a regular basis. Staff supported people to access health care services when they needed to and ensured people had choice when they supported them with meals.

Staff were recruited safely and had up to date training and ongoing support to fulfil their role.

The provider and staff understood their responsibilities to gain people's consent before providing care. People had maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 20 October 2017).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to the safe management of medicines, the effective management of complaints and governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during the inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Our 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 Care Act 2014.

Inspection team
One inspector carried out this inspection.

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

The service had a manager registered with the Care Quality Commission. This person was also the provider and legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or 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 the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the provider, a member of the provider's

management team, and four care staff.

We reviewed a range of records. This included four people's care records. We looked at two staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested copies of staff rotas and contacted local authority commissioners who had referred people to the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● People and their relatives did not raise any concerns about medicines. However, we found they were not managed safely. The provider did not always identify the support people needed with their prescribed medicines. One person's care plan stated the GP had given authorisation for their medicines to be crushed and administered. However, there was no guidance about how the medicines were to be crushed and administered and no record of authorisation from the GP regarding this. A staff member told us, "There was no information to read when I visited (Name of person) for the first time; a family member showed me how to do it as they have a proper crusher". The lack of written guidance put the person at risk of harm.

● Another person's care plan stated carers should apply any prescribed creams. There was no information on what creams had been prescribed or a topical medicine administration chart (TMAR) guiding carers on how and where to apply the cream. This placed the person at risk of not receiving their medicines as prescribed.

● Medicines were not recorded safely. Staff did not use the provider's E-MAR system or paper MAR charts to record the administration of medicines or creams. We found that medicines were being recorded as administered in the daily care records, which did not follow best practice on administering medicines and put people at risk of not receiving their medicines as prescribed.

● There was a lack of oversight of the management of medicines. No audits of medicines had been carried out since December 2019 and the provider had not been aware of the concerns we identified. This meant they had not assured themselves that people were receiving their medicines as prescribed.

Assessing risk, safety monitoring and management

● Risk assessments were not always comprehensive or up to date. Some people were referred to the service for a short package of care of up to twelve weeks, after a stay in hospital. The provider relied on information received from commissioners and did not always carry out their own assessments in a timely way. We saw the information was not always reviewed to ensure it remained relevant. For example, one person's pre-existing assessment had not been reviewed since they were referred to the service in January 2020. This meant the person was at risk of receiving care that did not meet their needs.

● Another person's assessment stated their skin integrity was at risk. The risk assessment in place did not identify the risks to the person's skin or give details on how staff should minimise the risk or monitor for any deterioration. The lack of information placed the person at risk of receiving unsafe care or treatment.

● Staff told us they did not always have sufficient information on how to manage risks, when they visited people at short notice due to staffing changes. A staff member told us, "My rota was changed at the last minute. The notes on my phone didn't give me enough information and I had to go with advice from the person's family. We are going in blind sometimes". This placed the person at risk of receiving inconsistent or

unsafe care. The staff member added they had raised this with the provider, but no action had been taken.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks were effectively assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They assured us that risk assessments were being reviewed and MAR were now in place and would be monitored closely to ensure people received their medicines as prescribed.

Staffing and recruitment

● The provider had not ensured people received a consistent and reliable service. Whilst people did not raise concerns about missed calls, they told us staff were consistently late for their care calls and sometimes did not stay for the allocated time. One person told us, "I've had to ring up as I get very anxious [when they are late]. The traffic can make them late but they don't let me know". A relative told us, "The care is fine, they can't keep to the times. They should come at 8am but they sometimes don't come till 11am and at night they don't get here till 11pm, when they should be here at 9pm. I have to wait up and can't get to bed".

● Care calls were not always planned to allow travelling time, which meant staff frequently ran late and people sometimes felt their care was rushed. A staff member told us, "My first call is at 6.30am, I finish at 7am. My next call is 7am but I don't arrive until 7:30 because I am a walker, so I'm always running late. The manager is aware of this".

● The provider monitored calls for punctuality and was aware of people's concerns. They told us they had taken on a number of additional packages from local authority commissioners under their hospital avoidance programme. They said, "We've found ourselves making calls in locations where we have no staff and we've not been able to keep to the times. I told commissioners this at the start and have asked them to take some packages back, but we have still got them".

● The provider told us recruitment of staff was ongoing and they were providing cover for calls when needed and would not be accepting any new packages of care unless they had sufficient staff to meet the preferred call times.

● We saw the provider followed safe recruitment procedures and carried out checks to ensure staff were suitable to work with people.

Learning lessons when things go wrong

● Staff were familiar with the accident and incident reporting procedures. Whilst the provider told us investigations were carried out and learning shared with staff, they were unable to provide evidence to support this.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of harm. Staff had received training and recognised the potential signs of abuse. They knew how to raise concerns both at the service and externally, if they needed to.

● The provider had effective systems were in place which demonstrated that any concerns were reported and investigated promptly, using local safeguarding procedures.

Preventing and controlling infection

● Staff had received training and understood their responsibilities to follow infection control procedures to keep people safe from the risk of infection.

● We saw gloves and aprons were made available to them whenever they visited the office.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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

- As noted in Safe, the provider did not always carry out timely assessments and relied on pre-existing support plans from commissioners to plan people's care. However, these were not always reviewed which meant we could not be sure staff had up to date guidance on people's ongoing needs.
- Assessments that had been completed listed people's long-term health conditions. However, they did not explain how these conditions affected the person and there was no evidence that information from national organisations or health professionals were used to plan people's care and support.
- Whilst staff we spoke with had a good understanding of people's needs, the lack of written guidance meant we could not be sure people's care and support was planned and delivered in line with best practice.

Staff support: induction, training, skills and experience

- People and their relatives generally felt staff had the skills and knowledge to provide good care. Staff completed an induction and undertook a range of training relevant to the needs of people using the service. Staff who were new to care competed the Care Certificate, a nationally recognised qualification which ensures staff have the skills and knowledge to work in the health and social care sector.
- When needed, staff received specialist training, for example PEG feeding (providing nutrition through a tube into the stomach). Staff knowledge and understanding was checked by the provider's trainer, who was a qualified nurse.
- Staff received ongoing support through supervision and an annual appraisal, which gave them an opportunity to review their performance and discuss any training needs.

Supporting people to eat and drink enough to maintain a balanced diet

- People who received support with their meals told us they were supported to have choice and had their preferences met.

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

- People retained responsibility for managing their own health but told us the staff supported them to access other health professionals if needed.
- Staff were aware of what they should do if people's health deteriorated, for example when to call the GP or an ambulance. They told us they always stayed to reassure the person until either the family arrived or the ambulance.

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 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 interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● People and their relatives confirmed that staff sought their consent before supporting them. One person told us, "I would tell them if I didn't want them to do something".
● Staff had received training and understood their role in supporting people to make their own decisions as far as possible.
● People's capacity to consent to their care and support was kept under review. The provider told us they involved people's family and other relevant professionals if they had any concerns. This assured us that people's rights would be upheld.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People did not consistently receive timely support that promoted their dignity. One person's relative told us, "There is no reasonable consistency in times. (Name of relative) is very proud and independent and always wants to be up and dressed before staff arrive. They [staff] don't let us know when they are running late so (name of relative) can be sitting around waiting for them".
- People felt their care was sometimes rushed because staff were under pressure to get to their next call. One person said, "Some staff stop and talk but others are always in a hurry". A relative told us, "Some don't even take their coat off".
- People told us staff respected their privacy. One person said, "The staff stand outside the shower and come and help dry me down [when I'm ready]". A relative told us, "The staff always close the curtains when they support (Name of person) in the front room".
- Staff encouraged people to maintain their independence. One staff member told us, "I always ask people do you want to do this for yourself and go with what they want". Another said, "We always encourage and give praise to ensure people do things for themselves".

Supporting people to express their views and be involved in making decisions about their care
- People and their relatives, where appropriate, were involved in making decisions about their care. The registered manager was aware of people's preferences for call times and consistent care staff and was working to resolve this.
- People were supported to access advocacy services when needed. Advocates work with people to ensure their views are listened to.

Ensuring people are well treated and supported; respecting equality and diversity
- People and relatives were positive about the staff they saw on a regular basis. One person said, "I do see lots of different staff but this week it's been just the one; they are quite good". Another said, "The regular ones are both good and really caring. They stop and talk; the others are in are hurry are not as good".
- Staff demonstrated a caring approach to people and their relatives. One staff member told us, "You should always put yourself in the position that you are caring for your own loved ones". Another said, "We always talk to relatives".
- Staff had received training in equality and diversity and discussions showed they recognised people's individuality. They described how they supported people living with dementia, by singing different songs they liked and talking about 'the old days' with people. One staff member said, "I remember the training we had which described the different stages of dementia as a book case that begins to shake and gradually fall

down. It has stayed with me and makes me more patient".

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- People and relatives knew how to make a complaint. However, they were not confident that the provider fully explored their concerns and responded in good time. For example, a relative told us their family member had raised concerns about a member of staff. They said, "(Name of person) felt the manager was giving them the run around as they called several times and got no answer. We called and got an answer straight away, we believe it's because we called from a number they didn't recognise. Although the manager did take some action, we don't think things were fully investigated. We feel we've been palmed off as promises made haven't been carried out".
- The provider had not established an accessible system for recording and responding to any complaints. They told us they had not received any formal complaints; however they discovered a misfiled complaint when searching for other records we requested. This did not assure us that complaints were consistently recorded, investigated and prompt action taken in response to any failures identified.
- The provider did not record informal complaints or grievances and told us they were unaware of the complaint raised with us. They told us, "If people don't tell me they want to complain formally, it won't be recorded". However, they had recognised that improvements were needed and had installed a telephone recording system which was reviewed daily.

The above concerns are evidence that complaints and informal comments and grievances were not consistently recorded and acted on to ensure people's concerns were addressed. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People did not always receive personalised care that met their preferences; care calls were not always at their preferred times or delivered by consistent care staff. Despite this, people and their relatives told us when things worked well, they were happy with their care. A relative told us, "A few visits are brilliant, (name of person) has their favourite carers and they have a laugh and a joke, which makes things better".
- As noted in Safe and Effective, care plans were not always developed in a timely way when people were referred to the service for a short stay. However, plans that were in place recorded people's preferences for how they wanted to receive their care, for example, how people wished to be supported with personal care. We saw these were reviewed with people and their relatives to ensure they remained relevant.
- The provider told us they had worked hard to develop personalised plans and would take immediate action to ensure they were in place for everyone supported by the service.

End of life care and support

● Whilst the service was not supporting anyone at the end of their life, discussions with staff showed us they made every effort to ensure people, their families, friends and palliative care professionals were actively involved in planning their end of life care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider was not aware of the AIS. However, they told us that information was available in large print for people who had poor eyesight if needed.

● Discussions with staff showed people's preferred communication methods were identified and met. For example, a member of staff told us a person used text messages to contact the service.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- There was a lack of oversight of the service. The provider told us they had been under pressure since the care co-ordinator left at short notice in December 2019. The service had grown rapidly between November and December 2019, with increased demand from local authority commissioners. It was evident the care co-ordinator had taken a lead role in quality monitoring and assurance arrangements, and the provider was struggling to balance the demands of managing the safety and quality of the service, whilst regularly covering care calls.
- Systems to monitor and assess the quality and safety of the service were not effective and had resulted in breaches of the regulations. Medicines administration records had not been completed since December 2019 and a mixture of electronic and paper-based records were being used to record the support staff provided. The provider told us they had reviewed these records but could not provide any evidence to support this. This meant we could not be sure people received their care and support as planned.
- The provider did not have a systematic approach to determining the number of staff needed to maintain a consistently reliable service. Rotas were not planned to allow sufficient travelling time, for example, some staff had to travel long distances to get to calls, sometimes on foot, which meant they were regularly late for calls.
- The provider's call monitoring system was limited to sending an email alert for each individual call. This meant the provider did not monitor punctuality across the service, which meant people were at risk of not receiving their planned care.

We found no evidence that people had been harmed however, systems for identifying, capturing and managing risks and concerns at the service were not effective. This placed people at risk of harm. 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 assured us that risk assessments and care plans were being brought up to date and MAR charts were now in place and would be monitored closely to ensure people received their medicines as prescribed.

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 the requirements of the duty of candour. However, people's comments and

shortfalls we identified in relation to the management of complaints meant we could not be assured they were consistently met.
● The provider complied with the requirement to notify us of important events in the service, which enables us to check they had taken appropriate action. In addition, the provider displayed their most recent rating at the office and on their website. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Although people had mixed views on how well the service was managed, overall people felt the provider was open and honest with them when they contacted the service. For example, one person told us, "(Name of provider) came to see us and admitted they can't keep to the times; they've asked [commissioners] to find an alternative care agency".
● Most staff gave positive feedback about the provider and their management team, comments included, "They always check we are okay", and "(Name of provider) is a good manager, we are like one big family". However, one staff member felt things had deteriorated after the provider's care co-ordinator left in December 2019. They told us, "Morale is rubbish, everybody just moans, rotas are changed, and clients are unhappy".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had systems to gather feedback on the service which included quality assurance surveys and telephone calls. However, the records we looked at were either undated or dated back to 2018, which meant we could not be sure people's views were consistently sought and any improvements needed made.
● The provider subscribed to an external organisation, who rated homecare services based on people's responses to a survey handed to them by the provider. Although the website displayed a positive rating, it was not a reliable indicator of people's current views as the last review for the service was August 2019. The provider was unable to give us an explanation for this.
● We could not be assured that the provider held regular meetings with staff. The provider told us a meeting had been held recently, whilst staff were unsure and thought they had not had one for some time. The provider was unable to provide minutes of meetings held after January 2019, which meant they could not assure us that staff were fully involved in the running of the service.

Continuous learning and improving care; Working in partnership with others
● The provider was committed to making improvements at the service. They told us, "I wasn't prepared for how quickly demand would grow when we started working with the local authority; I've asked them on numerous occasions to take some packages back but they haven't been able to find new agencies, so we are doing our best; but it isn't how I want things to work".
● The provider and staff demonstrated commitment to the people they were supporting, and we saw examples of how they worked with other professionals to ensure people's needs were met.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established and operated an effective system to ensure any concerns, grievances or complaints would be investigated on and improvements made where needed.

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 did not have effective systems to manage medicines safely. Risk assessments were not always detailed or kept up to date to ensure staff had clear guidance on how to support people safely.

The enforcement action we took:

We issued a warning notice and told the provider to make improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective oversight of the service. Systems to monitor the quality and safety of the service were not effective in identifying shortfalls and driving improvements.

The enforcement action we took:

We issued a warning notice and told the provider to make improvements.