

Our Care Ltd

Our Care Ltd

Inspection report

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

Date of inspection visit:
27 October 2022

Date of publication:
11 January 2023

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

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 personal care support to approximately 18 people.

People's experience of using this service and what we found

People did not always receive their medicines in a safe way. People did not always have care plans and risk assessments in place to give clear guidance to staff to meet their needs.

People were not always supported in a safe way to drink where they required thickener in their fluids. People did not always have access to healthcare professionals in a timely way when there were changes to their needs.

Quality assurance tools were not in place to identify concerns we found at this inspection around medicines and people's care records.

People were supported to have 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.

People's care plans did not always contain comprehensive information about their preferences. We have made a recommendation about the review of how these are reflected in people's care records.

People did not always have information about their care needs recorded in their care plans. We have made a recommendation about the review of people's care records to ensure they contain information about their communication needs.

People were supported by staff they described as 'kind' and 'caring'. People were supported to remain independent and their privacy and dignity was promoted. People felt able to raise concerns and these were dealt with in a timely way.

People were supported to receive care at times they preferred by regular staff. People did not feel rushed and told us staff knew them well. People were supported by safely recruited staff who received regular training. Staff supported people in line with infection control guidance.

People felt able to give their feedback on the service and knew who the provider was.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published April 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about people's care and support. A decision was made for us to inspect and examine those risks. The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

The provider worked with us during our inspection to reduce the significant concerns we found around people's support with medicines. This reduced the imminent risk to people during our inspection.

Enforcement and Recommendations

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 people's safe care and treatment and the oversight at the service.

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 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 always well-led.

Details are in our well-led findings below.

Requires Improvement ●

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 Health and Social Care Act 2008.

Inspection team

This inspection was completed by 2 inspectors.

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 the provider was also the registered manager at this service.

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.

Inspection activity started on 25 October 2022 and ended on 28 October 2022. We visited the service on 26 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 and professionals who work with the service. 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

During the inspection we spoke with 4 people who used the service and three relatives of people who used the service. We looked at care records of 5 people and multiple medicine records. We looked at documents relating to staff recruitment, training and the oversight at the service. Following our inspection, we reviewed additional documentation in relation to people's medicines and care records based on the concerns we identified during our inspection.

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 requires improvement. At this inspection the rating remained 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to continually assess the risks relating to the health, safety and welfare of people using the service. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

- People did not always have care plans and risk assessments in place where they were at risk of a break down to their skin integrity. For example, one person had a pressure area on their skin and had no guidance in place to support staff to meet this need. This placed them at risk of not receiving care in line with this need, placing them at increased risk of harm.
- People did not have health specific care plans and risk assessments in place. For example, people with diabetes had no care plans and risk assessments in place to reflect this. This placed them at risk of not receiving care to meet these needs as staff did not have clear guidance on how to identify signs of deterioration or when to seek support.
- People who required oxygen to be used and stored within their home had no risk assessments in place to provide staff with clear guidance on the safe administration and storage of this. This placed people at increased risk of their oxygen not being stored safely and therefore increased the risk of being harmed should there be a fire.
- People did not always receive consistent care in line with their drinking needs. For example, one person required two scoops of thickener to be added to their drinks. Thickeners are prescribed by the GP and are added to drinks to help reduce the risk of choking. However, staff had not documented they had given this person their thickener and staff we spoke with were not always clear on the amount of thickener this person required to support them to drink safely. This placed the person at increased risk of choking.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection to review people's care plans and risk assessments to make improvements where these were required. We will check these improvements have been made at our next inspection.

Using medicines safely

At our last inspection the provider had failed to establish and operate safe systems to ensure people received their medicines as prescribed. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

- Medicines were not administered safely. At our last inspection we found staff were administering people's medicines without clear medicines charts in place. At this inspection we found this was a continued concern. For example, staff were administering morphine to a person without this being recorded on their medicine's records. Whilst this medicine was prescribed, staff had not got clear instructions on when or how this was to be given recorded on the person's records. This placed the person at significant risk of harm.
- People did not receive their topical medicines in a safe way in line with the provider's policy. For example, staff were applying people's creams without confirmation these were prescribed and these being recorded on people's medicines records. Staff had recorded applying unnamed creams to one person on 8 occasions. This meant there was no clear record of what cream staff had administered and whether this cream was prescribed for this person. This placed them at risk of harm.

Systems had not been established to ensure medicines were administered safely and records reflected this. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to review people's medicines records to make improvements where these were required. We will check these improvements have been made at our next inspection.

Learning lessons when things go wrong

- The provider had not learned lessons where things had gone wrong. For example, they had failed to make the required improvements to people's care and supporting documentation since our last inspection.
- The provider failed to ensure they were reviewing and taking appropriate action where incidents occurred. For example, staff created an 'alert' on the online system where there had been a change or incident regarding people's care. However, the provider had failed to review all alerts and take action to ensure improvements were made where required. We found a person had 2 alerts that had not been actioned on their care records in relation to their skin integrity. This placed them at risk of prolonged harm.

Staffing and recruitment

- At our last inspection we identified concerns about people not always receiving a consistent and reliable service and staff not given enough time to travel between care calls. At this inspection significant improvements had been made and people were receiving their care the time they had chosen by regular staff.
- There were enough staff to meet people's needs. One person told us, "The staff come on time. They are the same staff other than on their days off they let me know." Another person told us, "[Staff] always offer to help with anything. They stay for the right amount of time and sometimes longer. They never rush me. "
- Staff were recruited safely. Staff had received checks from the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decision and prevent unsuitable people from working with people.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person told us, 'I feel very safe with the carers coming in.'
- Staff understood the different types of abuse and were clear on how to escalate potential concerns. Where concerns had been raised these had been referred to the local authority safeguarding team for further investigation.

Preventing and controlling infection

- People were supported in line with infection control guidelines. There was an infection control policy in place which staff were adhering to. One person told us, "[Staff] always wear the masks and they always wear gloves and aprons when they do my food."

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

- Staff did not always have sufficient guidance in place to ensure people's health needs were met in a consistent and safe way. For example, people's health conditions were listed within their records, but the provider had failed to include any further guidance on how to support people with these conditions. This placed people at risk of not receiving care in line with these needs.
- Staff understood people's needs. However, the lack of written guidance meant we could not be sure people's support was delivered in line with best practice guidance and in people's preferred way.

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. 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.

- Whilst no one at the service lacked capacity the provider had systems in place to assess people's capacity should this change. For example, the provider told us they would complete the relevant assessments involving the person, their relatives and professionals to ensure where people lacked capacity decisions would be made in their best interests.
- Staff received training and understood their role in supporting people to make their own decisions. For example, one staff member told us, "All people have some degree of capacity. It's about us making sure people consent and supporting them to make decisions."
- People told us staff sought their consent before providing their care. One person told us, "They always ask before they do anything."

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

- As reported in safe, a person was not supported to drink safely in line with their needs. This placed them at risk of choking.

- People were supported to eat and drink in line with their preferences. For example, people gave positive feedback around staff offering choice at mealtimes and being 'good' in the kitchen.

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

- Staff worked with other health and social care professionals where people's health or wellbeing had deteriorated. However, we could not be assured this was in a timely way. For example, where a person had experienced a deterioration in their skin integrity there was a delay of 5 days in this being reported to the district nurses as staff had not reported concerns to the management team.
- Staff were aware of what they should do if a person's health deteriorated quickly. For example, staff told us they would call the GP or an ambulance.

Staff support: induction, training, skills and experience

- Staff received a combination of online and face to face training to help them support people. One staff member told us, "The training was really good and informative."
- People and their relatives confirmed staff were well trained. One person told us, "[Staff] all seem well trained. They know what they are doing."
- Staff received an induction and training before caring for people on their own. Where staff had no care experience, they completed The Care Certificate and all new staff had a period of shadowing more experienced staff. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people were not well-supported.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff did not always have clear guidance in place to support them to know and understand people's needs and preferences. For example, one person's care plan stated they had diabetes but contained no guidance on how this impacted on the support they required. We raised this with the provider who told us this person no longer had diabetes. This placed the person at risk of not receiving their good care in line with their changing needs.
- Staff did not always have a comprehensive understanding of people's healthcare needs to ensure they consistently received support in line with these. For example, a person living with dementia had no reference to this within their care plan to ensure staff understood how this impacted the person and how they were treated.
- People had regular staff who they described as 'caring' and 'kind'. For example, one person told us, "[Staff] are all good. They are caring and kind." Relatives also shared this opinion, one relative told us, "I cannot fault the staff. They all know my [relative] well."
- Staff spent time talking with people during their care and did not rush people. . One person told us, "[Staff] stay for the right amount of time and sometimes longer. They never rush me. I talk a lot to them."
- Staff had training in equality and diversity and respected people's individually. All people and relatives we spoke with gave positive feedback about the staff and their support.

Respecting and promoting people's privacy, dignity and independence

- People were not always supported to remain independent. For example, a person's care plan advised staff were to prompt the person with their medicines but not to administer them. However, staff were recording they had administered these medicines to the person. This did not promote their independence.
- Staff promoted people's dignity. A relative told us, "The [staff] are all nice, polite, well mannered. They've built a good rapport with [my relative] and respect their privacy."
- Staff told us how they protected people's privacy. For example, staff told us how they closed people's curtains and door and covered them with towels where necessary.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives were appropriate were involved in the planning and delivery of their care. One relative told us, "I had a review with [my relative's] social worker yesterday and told her how good I thought [the staff] were."
- The provider supported people to access social care professionals, were required, to review and make changes to their care and support.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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 plans did not contain detailed information about their preferences. Whilst some people's likes and dislikes had been included these were limited around food and not around other aspects of their care. This meant staff did not have clear guidance to enable them to consistently provide care in line with people's wishes.

We recommend the provider reviews people's care plans to ensure these reflect their needs and preferences. We will check this at our next inspection.

- People and their relatives gave positive feedback about the staff who supported them. One relative told us, "[The staff] are very kind to her. [Staff] have been really good."

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 (AIS). 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 not always recorded within their care records. Staff we spoke with knew how people they visited regularly communicated. However, having no guidance in place to support people to communicate in line with their needs placed people at risk of not consistently receiving care in line with these where their regular staff were not available.

- At the last inspection the provider was not aware of the AIS. At this inspection the provider was aware of AIS and told us they would provide information in large print where people required this. However, as people did not have communication plans in place they continued to not be meeting the requirements of AIS.

We recommend the provider reviews people's care plans to ensure these reflect their preferred method of communication. We will check this at our next inspection.

Improving care quality in response to complaints or concerns

At our last inspection we found systems were not always in place to record and respond to complaints and

people were not confident their concerns would be responded to promptly. This was a breach of Regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

At this inspection we found improvement had been made and the provider was no longer in breach of regulation 16.

- The provider had a system in place to monitor and respond to complaints in a timely way. Where people had raised concerns, the provider had responded to these in full. For example, a relative had raised concerns about staff marking a person's carpet and the provider had paid to have their carpets cleaned.
- People and their relatives felt able to raise concerns with the provider. For example, one relative told us, "I've spoken to [the registered manager]. They have been very helpful and obliging."

End of life care and support

- At the time of inspection, no one was receiving end of life care. The provider told us they would involve people, their relatives and health professionals, where required, should they begin supporting a person at the end of their life.

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 inadequate. At this inspection the rating for this key question has changed to requires improvement. 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; Continuous learning and improving care

At the last inspection we found the provider failed to ensure there was effective governance systems in place to ensure people consistently received safe care in line with their needs. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found whilst some improvements had not been made further improvements were required and the provider remained in breach of regulation 17.

- The provider continued to fail to ensure there were effective systems in place to monitor medicines. For example, there was no oversight of how medicines records are completed and maintained. This meant we could not be assured people had always received their medicines as prescribed which placed people at continued risk of harm.
- The provider had no system in place to monitor people's care records to ensure these remained accurate and up to date. For example, following a person experiencing changes in their skin integrity, no changes had been made to their care records to ensure staff had guidance in place to meet their needs safely. This placed the person at risk of harm.

Systems had not been established to ensure quality assurance tools were in place and effective at identifying where improvements were required. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection to respond to our concerns. They completed an action plan for improvements to the quality assurance and oversight at the service. We will check this at our next inspection.

- At our last inspection people did not always have consistent staff who visited at the times they were planned to and stayed for the duration of this planned time. At this inspection improvements had been made. The provider had limited the people the service supported in line with their capabilities to ensure people had regular staff who visited them. The provider had also reduced the areas they provided support in to ensure staff had enough travel time between visiting people. This meant people received their care at the times they needed this.

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

- Whilst the provider understood the requirements of the duty of candour; as they had not identified all concerns around people's medicines administration we could not be assured they were meeting these.
- The provider did not always notify CQC of potential safeguarding incidents at the service as they were required to do so. For example, we found 2 safeguarding referrals the provider had not notified us about.

Working in partnership with others

- The provider worked with other health and social care professionals to make improvements to people's care where this was required. Although, as discussed in domain of 'effective', changes in people's needs had not always been identified by the provider in a timely way.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- All people we spoke with gave positive feedback about the provider and their responsiveness. One person told us, "If I had any problems I would speak to [the provider], they are very good. I am completely satisfied with them."
- All relatives we spoke with were confident in the provider's ability to manage the service. One relative told us, "[The provider] is always available to take my call, night or day if I have concerns. They have taken swift action where I have needed them to."
- Staff also gave positive feedback about the provider and had access to supervision and staff meetings which they described as 'helpful'.
- The provider held reviews with people and their relatives to gain feedback about the care they received.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Systems were not in place or effective to ensure people received their medicines in a safe way. People did not have care plans and risk assessments in place which reflected their healthcare and changing needs.</p>

The enforcement action we took:

We requested the provider send us a regular action plan to update us on improvements that were required at the service.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems were not in place or effective to monitoring the quality of care and support at the service.</p>

The enforcement action we took:

We requested the provider send us a regular action plan to update us on improvements that were required at the service.