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Professional Carers

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Professional Carers is a domiciliary care service that provides support and personal care to older people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of our inspection 227 people received support from the service. Most of the people using the service lived in the community. The service however did support 22 people who lived in their own home in a specialist Extra Care Housing called St Oswald's Court in Birkenhead.

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

This was a focused inspection looking at the domains of safe and well-led only. At the last inspection, the provider was rated good and outstanding respectively in these domains. At this inspection, these domains had deteriorated to requires improvement.

Medication management was not safe. Adequate systems were not in place to check that people's medicines were administered as prescribed. Medication administration records were not always clear or accurate. One of the people whose care records we looked at, had one of their medicines secondary dispensed without appropriate risks assessments in place to support this safely. This meant it was taken out of its packaging and left for the person to take later on, or for example, for a relative to support them to take this medicine at a later time. This was not good practice.

Some people's care was not always adequately planned or delivered. For example, some people's care plans lacked sufficient detail and guidance for staff on their needs and risks. Where people had specific requirements or wishes in relation to their care, these were not always respected. Some people's visits were completed by a range of different carers which impacted on people's continuity of care.

Staff recruitment required improvement to ensure that people's previous employment history and conduct was properly verified as suitable prior to appointment.

The management team told us that they had experienced no major staffing issues during the Covid 19 pandemic. Despite this, the deployment of staff during the pandemic did not always adhere to best practice. For example, by minimising the number of different staff members' conducting people's visits. We spoke with the provider about this.

Staff had access to sufficient supplies of Personal Protective Equipment (PPE) and received regular updates from the provider on the management of risks related to Covid 19. There were organisational Covid 19 policies and guidance in place for staff to follow which followed best practice. However, staff lacked specific guidance on how to care for individual people living with Covid 19.

There were systems in place to monitor the quality and safety of the service however these were not always effective. The audits had not identified the concerns we identified during the inspection. This aspect of governance required improvement.

During the inspection, the management team were open and approachable. They were passionate about the service and were aware of their legal responsibilities as a health and social care provider.

Staff morale was good and staff told us they felt supported by the management team to provide good care. People we spoke with spoke positively about care staff and said they supported them with the things they needed help with. For the most part, people's visits were completed on time or within an acceptable time frame.

Rating at last inspection and update

The last rating for this service was outstanding (published 29 October 2019). At the last inspection the domains of safe and well led were rated good and outstanding. At this inspection, these domains had deteriorated to requires improvement. A breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medication management was identified.

Why we inspected

We received concerns in relation to the quality and safety of the service. We also reviewed and took into account other intelligence including notifications sent to us by the provider in relation to Covid 19. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from outstanding to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Professional Carers on our website at www.cqc.org.uk

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We identified a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to risk and medication management. We will continue to monitor the service.

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 well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Professional Carers

Detailed findings

Background to this inspection

The inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team

This inspection was undertaken by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type

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

Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is either bought or rented and is the occupant's own home.

People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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

Notice of inspection

This inspection was announced the day before the inspection. This was because arrangements had to be agreed with the provider prior to our visit to mitigate the risk of any cross contamination or transmission of the Covid 19 virus.

What we did before the inspection

We reviewed information received about the service since the last inspection. We contacted the Local

Authority Commissioning Team and Local Authority Quality Improvement Team and gained their feedback about the service. We used all this information to plan our inspection.

During the inspection:

We spoke 25 people using the service and/or their relatives. We spoke with the registered manager, the Director of Operations and three members of the care team. This included a carer, a field supervisor, and a trusted assessor. We reviewed a range of records including seven people's care records, a sample of medication records, four staff recruitment files and records relating to the management of the service.

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 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

- The management of medication was not always safe. The systems in place to mitigate risks associated with the administration of medication were not robust.
- Where people self-administered medication this had not been risk assessed or adequately reviewed.
- One of the people whose care records we looked at, had one of their medicines secondary dispensed without appropriate risks assessments in place to support this safely. This meant it was dispensed by staff and left for them to administer themselves later on. Meanwhile staff had signed the person's medication record to say it had already been taken. This was not good practice.
- It was not clear whether the service provider, person, or other representative was responsible for ordering people's medication. This resulted in some medicines not being available at the time of their administration.
- People's medication records were not always accurate or clear.

Unsafe management of medicines places people at risk from serious harm.

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

Assessing risk, safety monitoring and management

- Not all of the risks associated with people's care were risk assessed. For example, one person had a pressure sore, but staff had little information on the support required to prevent further skin breakdown.
- One person had a specific requirement in relation to their care which was not always respected. This caused distress for the person and was a potential risk to their well-being.
- In some cases, we found that people's rights were not respected in relation to risk management.
- People told us that staff supported them with the tasks they needed help with. People's comments included, "Happy at the moment with the help I get" and "Yes I get the care I need, they look after me" and "The help we get meets (name of person) needs. They are all very willing and agreeable".

Risks in relation to people's care were not always adequately identified or managed. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.

- People told us they felt safe with the staff supporting them.
- Safeguarding, accidents and other incidents that had occurred were properly recorded, investigated and

reported. This helped the service learn and improve from specific events.

Staffing and recruitment

- The management team told us that they had not had any major staffing issues due to the effects of the Covid 19 virus. Despite this, we found that the provider had not always adhered to best practice with regards to the deployment of staff during the pandemic. For example, some people had multiple staff visiting them.
- When asked if the same carers supported them most of the time, the majority of people said that a lot of different carers visited them. Their comments included "I get at least eight or ten different ones, ½ an hour four times a day"; "Various different carers come"; and "I did have regular staff, now they (Professional Carers) seem to change staff around too much, don't know who is coming". We spoke with the provider about this.
- Pre-employment checks on the safety and suitability of staff to work with vulnerable people were completed. Verbal references as opposed to formal written references had been sought from previous employers. These had not always been checked or verified properly or followed up with written confirmation.
- Staff spoken with told us they had enough time to ensure people's support was provided but said they did not have built in travel time between people's visits. Records showed people's visits were mostly completed on time or within an acceptable time frame.

Preventing and controlling infection

- Staff completed appropriate training and were aware of the need to control the potential spread of infection.
- The organisational arrangements in place to manage Covid 19 followed government guidelines but staff lacked specific guidance on how to care for individual people living with Covid 19.
- Sufficient supplies of personal protective equipment (PPE) was available. Staff confirmed this.

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 outstanding. At this inspection, this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The governance arrangements in place to audit the quality and safety of the service were not always effective. For instance, the systems in place failed to identify any concerns with risk management, medication management, staffing or people's experience of the continuity of their care.
- The Director of Operations and the registered manager were clear about their roles and responsibilities and were passionate about the service. They had not identified however that some improvements with regards to the service were required. This meant the issues we had identified had not been addressed.
- Staff were trained, felt supported and there were systems in place to promote continuous learning. Spot checks on staff practice were regularly undertaken to check on the quality and safety of people's care.
- Accident and incidents, safeguarding events and complaints were properly reviewed to ensure the service learned from and improved the support provided.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- People's continuity of care was not always prioritised to ensure it was person centred and promoted good outcomes for people. People's feedback included, "Our main concern is continuity of carers, I know it must be a difficult situation with Covid", "High turnover of staff, something must not be right, has a knock on effect with (family member's) care" and "(Name of person) is very confused, we would prefer more consistent carers".
- The people and the relatives we spoke with spoke positively about the staff providing support. Their comments included, "They (the carers) are smashing, very pleased", "Very good at what they do for me" and "I feel safe, they are very caring I can't fault them at all they will do anything for me".
- The management team were aware of their responsibility to report notifiable incidents to CQC. Notifiable incidents had been reported appropriately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service worked in partnership with the local authority commissioning team and social services to assess and support people in the community.
- The provider sought formal feedback from people using the service, their relatives and staff on an annual basis through the use of a satisfaction survey. Other methods of engaging and involving people were also

used. For example, regular telephone checks, care reviews and a suggestion box. One person told us, "The office ring me every couple of months, to see how I am doing and see if I'm satisfied".

- The service was involved in a number of initiatives to help build relationships in the community. For example, they continued to be involved in local reach out project to help get people back into work and organised fundraising events for recognised charities such as the Alzheimer's Society.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always adequately assessed or managed. Medication management was not safe.