Pleasant Valley Care Limited

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Inspection report

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Pleasant Valley Care is a domiciliary care agency providing the regulated activity of personal care to people living in their own homes. The service provides support to older people, people living with dementia and people with physical disabilities. At the time of our inspection there were 31 people using the service.
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.

People's experience of using this service and what we found
At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person who was in receipt of the regulated activity of personal care. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Care
Care plans lacked guidance for staff on how to support people with specific health needs. Some relatives felt staff did not know enough about their health care needs to support them appropriately. A staffing crisis had led to some missed care calls. Relatives and people receiving care told us calls had since not been missed but were still often late. The service was providing care call 'windows' or broader time as agreed by the funding local authority. However, they had not ensured people who had a need for specific calls times were accommodated.

Right Care
People receiving care and their relatives shared mixed views on the support they received to eat and drink well. Some felt not all carers were good at preparing meals, others were happy with the support they received. Care plans provided guidance for staff on what people could and could not do for themselves. People were supported by staff who received a detailed induction and regular training.

Right Culture
People and relatives had mixed views about the management team. Some were unhappy with the level of consultation and communication; they told us they did not feel listened to. Some were happy with this aspect of the service and described the care manager as 'lovely'. The provider's quality assurance systems had not identified some of the concerns we found at inspection. In some cases, learning from mistakes made had not been sustained over time. However, the provider had made numerous changes to try to improve service delivery.

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.

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 5 July 2019)

Why we inspected
We received concerns in relation to missed and late care calls. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

You can see what action we have asked the provider to take at the end of this full report. The provider took action to address some of the concerns during the inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Pleasant Valley Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
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 02 November 2022 and ended on 15 November 2022. We visited the location's

office on 02 November 2022.

What we did before the inspection
We reviewed the information we had received about the service. 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
We spoke with 2 people who used the service about their experience of the care provided. We spoke with 9 relatives about the care their loved ones received. We spoke with 11 staff, including the registered manager, care manager, HR staff, the duty manager and senior care staff. We reviewed a range of records. These included 4 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management

● Some people's care plans lacked guidance for staff on how to support people with specific health care needs. For example, a person with diabetes had their diagnosis in their care plan, but nothing about how well their condition was managed. There was no information for staff about signs to look out for that the person may be experiencing low or high blood sugars. There was no guidance on what to do in the event of concerns about low or high blood sugars. This left people at risk of signs and symptoms of deterioration in their health being missed by staff. We discussed this concern with the provider who agreed to add this guidance to people's care plans. This work was commenced during the inspection.

● During a staffing crisis a few months prior to inspection, some care calls had been missed and some were attended late. People and relatives told us calls were no longer being missed but calls were sometimes late. Staff attending calls time late was a significant source of concern to some relatives and people.

● People who had health needs requiring specific call times had not always received care in a timely way. This had impacted upon people's wellbeing. For example a person with diabetes struggled to regulate their blood sugars due to variance in the time of their morning call.

Systems and processes to safeguard people from the risk of abuse

● Some staff were not able to fully describe the process they would follow in the event of a safeguarding concern. Some staff did not know where the safeguarding process and procedures were should they need to refer to it. There was however clear evidence staff had shared concerns with management appropriately.

● When safeguarding concerns had been raised, they had been investigated appropriately by the provider and they had worked alongside other agencies as needed.

● Staff had received training on how to recognise signs of abuse.

Staffing and recruitment

● Although we saw much had been done to streamline recruitment processes, there were still some aspects which were not robust. Some applications contained gaps in employment history, there was no evidence these had been explored further. One person's recruitment file only contained one reference. Lack of thorough recruitment checks can risk employment of unsafe or unsuitable staff. The provider agreed these checks were an important part of recruitment and every effort would be made to seek this information.

● The provider advised that in response to difficulties in recruiting staff they had begun to recruit suitable candidates from overseas. During the initial weeks of this process difficulties in supporting the new staff had resulted in the missed care calls. The provider told us they now had sufficient numbers of staff.

● Appropriate safety checks had been made including Disclosure and Barring Service (DBS) checks which

provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff told us they felt the induction and training was helpful and had prepared them for their role. One staff member told us, "The training is really good and helped me."

Using medicines safely
● People received support from staff to make their own decisions about their medicines wherever possible.
● Staff received training to support safe medicines administration.
● An electronic system was used to monitor medicines administration and flag any errors; this was monitored live by the management team.

Preventing and controlling infection
● The provider had an infection control protocol in place which reflected the latest government guidance.
● People were supported by staff who had received training in infection prevention control.
● Staff confirmed they had access to supplies of personal protective equipment (PPE) to keep them and the people they supported, safe.
● Relatives confirmed staff wore appropriate PPE when supporting their loved ones.

Learning lessons when things go wrong
● Although there were systems in place to analyse incidents, there was not always evidence that monitoring had ensured lessons learned were embedded in daily practice. For example, relatives had raised a concern about how their loved one was receiving personal care. This had been investigated and addressed, but after a short time the concern arose again and continued.
● The provider had made numerous changes to address their difficulties in recruiting staff and supporting their staff with travelling locally to try to improve call times.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People receiving support gave mixed views about the skills and experience of the care staff. Some were very positive and named specific staff whom they felt were very good at their jobs. Others said they felt staff lacked skills and experience in specific areas.
- All staff told us they received a full induction and shadowed more experienced staff before beginning work.
- Staff were asked to complete the Care Certificate as part of their application process. 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. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- Staff received support in the form of supervision and appraisal, including observations of their practice.

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

- Relatives gave mixed views regarding the support people received to eat and drink. One relative told us their loved one had been given burnt food they couldn't eat, however other relatives told us they were happy with the support people received.
- Care plans provided guidance for staff on how people wanted to be supported with eating and drinking. This information included details about their appetite and preferences.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Staff completed assessments of each person's physical and mental health before they received support.
- With the exception of some people's needs in relation to specific health conditions, care plans were holistic and personalised. Staff were provided with details about how people wanted to receive care. These included details such as how and if a person would find it appropriate for staff to demonstrate affection or reassurance. For example, one person had said they would like an 'assuring smile', another liked a 'tap on the shoulder.'
- Staff met people's needs related to protected characteristics. For example, when people had a preference for the gender of their carer, this was accommodated wherever possible.
- Care plans showed evidence people and those who were important to them had contributed to their development and review.
- Staff were given guidance about what people could do for themselves and what they would need support with.

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.

● We saw an instruction in one person's care plan advising staff to 'insist' on providing personal care if they refused. The provider agreed this was not appropriate and showed how this wording had been replaced with appropriate guidance for staff.
● Staff received training on the principles of MCA, and they were able to tell us what decisions people could and could not make for themselves. They spoke respectfully about the people they supported and told us about respecting people's right to refuse care and support.
● People's care plans included a mental capacity section which outlined to staff what decisions people could make for themselves.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives.
● Staff worked with other professionals such as social workers, occupational therapists and GPs to ensure people received the support they needed.

Requires Improvement

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 requires improvement. The rating for this key question has remained 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

- Although quality assurance systems were in place, they had not identified some of the issues noted during this inspection. Recruitment process checks had failed to note that gaps in employment history had not been explored. They had also not identified the lack of second reference for one staff member.
- Care file audits had not identified the inappropriate instruction wording we found in one person's care plan telling staff to 'insist' on providing personal care.
- The provider had failed to ensure people with healthcare needs requiring specific call times had received their calls at a regular suitable time. The provider explained they were providing care calls within windows of time agreed by the local funding authority. The local authority had specified where there was a need for a more specific call time, this should be provided. For some people who needed specific call times, call attendance varied significantly. One person with diabetes who could not have their medicines until they had eaten had a 2 1/2-hour variance in their morning call over a month. This could impact upon their wellbeing and lead to less benefit from their medication. Systems to monitor care call times had failed to identify and address this risk.
- Some relatives told us they thought staff did not fully understand their loved one's health conditions. For example, some relatives felt staff did not understand dementia well. They gave examples of times when staff had caused people distress. For example one person would show signs of distress when staff asked them questions they couldn't answer. The provider advised staff were given general information about health conditions during induction which is why it was not detailed in people's care plans. Quality assurance checks on care files had failed to identify there was not enough information for staff to enable them to support some people adequately with their specific needs. This left people at risk of unnecessary harm.

The provider's quality assurance systems and processes had not always been effective, leaving people at unnecessary risk. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to address some of the concerns during the inspection. The provider told us they were working on improving call times with particular focus on people with need of specific call times.

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

characteristics

● We received mixed reviews from relatives about how engaged they were with the development of the service. Some told us they did not feel listened to when they had shared concerns. One relative said, "They talk the gift of the gab, but things are still the same, nothing changes." Another told us, "They listen but they do not do anything." Others said they were happy with communication and engagement from the service. One relative told us, "They have listened to us. We have regular conversations."

● The management team asked for feedback from people, relatives and staff about the service. They had also introduced 6 monthly wellbeing checks to review whether people were happy with the care they received.

● Where possible the service recruited staff, who spoke the first languages of the people needing support. The provider explained in some cases this had been difficult, but it remained a goal of the service.

Continuous learning and improving care; Working in partnership with others

● There were some concerns which had been raised by relatives but had not been resolved satisfactorily. This suggested there was scope for improvement in learning lessons when things go wrong.

● The provider kept up to date with national policy to inform improvements in the service.

● The provider had invested in the service and had put changes in place to aim to deliver improvements.

● The provider engaged in local forums to work with other organisations to improve care and support for people using the service and the wider system.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff told us they felt supported by the management team. One person told us, "If I don't know what to do I call [the management team] and they help me, and they are there for me personally."

● Staff told us they felt able to raise concerns with managers without fear of what might happen as a result.

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

● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of a person using the service, severe or moderate physical harm or prolonged psychosocial harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● The provider understood their duty of candour responsibilities and apologised when mistakes had been made.

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 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes had not always been effective, leaving people at unnecessary risk.