Passion Tree Care Services Ltd

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Passion Tree Care Service Ltd is a domiciliary care agency. It provides personal care for people living in their own houses and flats. 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
The provider had not always ensured they had systems in place to protect people from the risk of harm. Prior to the inspection we received a number of safeguarding concerns about the quality of the care people were receiving including concerns for people's health care needs and the management of infection prevention and control.

The provider had not always notified the relevant authorities when concerns were raised, and it was not always clear what actions had been taken to ensure risks had been mitigated. Systems in place to monitor the quality and safety of the service were not always effective.

We have made a recommendation about the provider's quality assurance processes.

People and relatives told us that the timing of their care calls was not always consistent, and care was sometimes rushed. People told us communication from the provider about changes to their care calls could be improved.

Despite the concerns raised, people and relatives generally spoke positively about the way the staff communicated with them and involved them in their care and felt comfortable raising concerns with the registered manager.

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 14 November 2018)

Why we inspected
We received concerns in relation to how the provider was keeping people safe from the risk of harm and abuse. The service had seen an increase in the number of safeguarding concerns raised over a ten-month period prior to the inspection. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. 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 Good to Requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Passion Tree Care Service Ltd 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 will continue to monitor the service.

We have identified one breach in relation to safeguarding people from the risk of abuse at this inspection.

Please see the action we have told the provider to take at the end of this report.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Passion Tree Care Service 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
The inspection was carried out by one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Passion Tree Care Service Ltd 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 means that 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.

We gave the service 24 hours' notice of the inspection. This was because 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 and professionals 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 nine members of staff including the provider, registered manager, quality manager and care workers. We reviewed a range of records. This included seven people's care and medication records, safeguarding documentation, recruitment and training files 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 and continued to review quality assurance records. We spoke with four people who use the service and seven relatives to understand their experience of the care provided.

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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- The provider had not always ensured appropriate systems were in place to keep people safe and protected from the risk of abuse. Prior to the inspection, there was an increase in the number of safeguarding concerns we received from people, relatives and health professionals regarding the care people received.
- These concerns included staff not responding appropriately to people's health needs including not reporting people's pressure wounds and unsafe moving and handling processes. Concerns were also raised about staff not wearing personal protective equipment (PPE) appropriately, not arriving when agreed and not spending the allocated amount of time with people.
- The provider had not always notified the Care Quality Commission or the local authority appropriately when these concerns had been raised. They told us this was because they had considered some concerns as complaints rather than safeguarding concerns. The provider had kept a log for recording safeguardings and complaints; however, information was not consistently recorded in either. This meant there was no clear oversight of what the issues were and what actions had been taken and we could not be assured people were being kept safe from the risk of harm.
- Staff meeting minutes demonstrated that the provider had addressed some of the concerns raised with staff. For example, we saw evidence of discussions regarding the correct use of PPE and how to respond to complaints. Staff had received safeguarding training and the provider had arranged updated training in areas where concerns had been raised. However, a high number of similar concerns continued to be raised and we were not assured that the provider had systems in place to address these concerns and mitigate the risks to people effectively.
- Risks to people's health and safety had been assessed; however, some of the assessments lacked detail. For example, one person's epilepsy risk assessment did not tell staff what they should do if the person did not recover as expected and another person's diabetes assessment did not include guidance on what to do if the person remained unwell. This meant staff may not know how to respond appropriately in these situations and people may not receive appropriate care and treatment.

The above evidence demonstrated a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust systems in place to protect people from the risk of abuse.

Preventing and controlling infection

- The provider had received a number of safeguarding concerns about staff use of PPE. This had been

raised with staff and updated guidance and information had been issued to staff to ensure they were aware of government guidelines. However, spot checks completed by the provider did not include any specific information relating to PPE or infection prevention and control.

● We received mixed feedback from people and relatives about staff use of PPE. One person told us, "Whenever we have seen them, they are always wearing PPE." Another said, "They could be better, they don't all wear masks and they should be wearing them all the time."

● The provider had completed infection prevention and control audits; however, these audits were only used to monitor the safety of the office environment and to ensure adequate PPE supplies were maintained and did not cover staff practice or knowledge.

Staffing and recruitment

● People and relatives told us care calls were sometimes rushed, and staff arrived at different times, making it difficult to ensure consistency of support. One person said, "In the mornings they are very good, but it seems a bit rushed at all the other times." Another said, "Occasionally staff have been in and out quite quickly. They are rushing about to get to the next house."

● Staff had been recruited safely to the service, with appropriate background checks completed.

Using medicines safely

● Staff were trained in the administration of medicines. The provider completed regular spot checks and audits to ensure medicines were given safely.

● Staff were able to tell us what they would do if they had any concerns about people's medicines. One member of staff said, "I've had online training and my competency and spot check recently, where they watched me give medication. If I had any concerns about people's medication, I would report it to the office or the on-call."

Learning lessons when things go wrong

● The provider had shared lessons learnt with staff. Where it was clear mistakes had been made, the provider was open about what actions would need to be taken if improvements were not made. For example, the provider had discussed disciplinary action if staff failed to report concerns or repeatedly failed to wear PPE appropriately or follow safe infection prevention and control practices.

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 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 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

- The provider had not always notified the Commission of incidents in line with their regulatory responsibilities. Following the inspection, the provider sent through these notifications retrospectively.
- The provider's documentation of concerns was not always accurate and lacked detail. Information given to the Commission and local authority by the provider regarding the number of safeguardings in the service was contradictory and unclear. This meant we could not be assured appropriate systems were in place to monitor risks to people's safety.
- The provider completed a number of audits to monitor the safety and quality of the service; however, these had not always effectively highlighted shortfalls in the service. For example, infection control audits and spot checks did not address the use of PPE and audits of care plans had not identified where risk assessments lacked important information for staff to follow.

We recommend the provider reviews current best practice to ensure effective quality and safety monitoring processes are in place.

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

- People and relatives generally spoke positively about the care they received from staff. One person said, "I think they are very friendly and polite, and they know how to help me. They always make me feel safe when they are helping me." Another person said, "They speak to you in a professional way, they also find out what you need, and you feel well looked after."
- Relatives and staff told us they felt comfortable raising concerns with the registered manager. One member of staff said, "I would go to [registered manager] and I know they would support me." A relative said, "When I wasn't happy with something, I told them, and I was happy with the outcome."
- The provider had recently recruited a new quality manager to review documentation. They told us they would be working alongside the registered manager to review how incidents and safeguarding concerns were managed. They told us, "We will contact people straight away and alert CQC and the local authority. It's important to say if something went wrong and learn what we could have done better."

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

characteristics

● The provider was in the process of updating their assessment and care planning documentation to ensure it was more person centred and, where they were supporting people with reablement care, to ensure the records contained more detailed information about what people wanted to achieve.

● People and relatives told us they felt involved in their care. However, we received mixed feedback about how well the provider communicated with them. One person said, "The communication isn't brilliant." Another said, "I will ring the office if there's a problem but sometimes there's a lack of communication."

●The provider completed satisfaction surveys with people and relatives to monitor the care provided. Following feedback from these surveys, the provider had implemented an action plan to highlight areas where improvements could be made.

Continuous learning and improving care; Working in partnership with others

● The provider had sought support from other health professionals when appropriate in order to meet people's health needs.

● The provider had used the resources and support provided by local hospices to develop and improve their end of life care for people.

● Where concerns had been raised about how people's reablement care was being delivered, the provider had taken on board feedback and introduced new guidance and documentation for people and relatives to improve communication and understanding.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have robust systems in place to protect people from the risk of abuse.