Premier Care Limited

Premier Care Limited - Trafford & Manchester Homecare Branch

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Premier Care Limited - Trafford & Manchester Homecare Branch is a domiciliary care provider. It provides personal care to adults and 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 the service supported 326 people with personal care.

People's experience of using this service and what we found
The risks associated with people's care were not always managed in a safe way. This included out of date care plans, poor management of home visits, high use of agency staff and poor management of medicines. This meant people were at risk of avoidable harm. Systems to manage safeguarding incidents had not been effective or consistent and we could not be assured that the correct processes had been followed. Opportunities to learn had been missed.

Quality issues identified at the last inspection had not been resolved. There had been a lack of robust systems in place to monitor the delivery of care and this impacted on the care that people received. Audits had not been effective at identifying or preventing issues occurring or continuing at the service.

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 17 February 2022) and there were two breaches of regulations. 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
We received concerns in relation to the safe management of visits to people's homes. As a result, we undertook a focused inspection to review the key questions of safe 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 requires improvement to inadequate.

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 focused and comprehensive inspection, by selecting the 'all reports' link for Premier Care Limited - Trafford & Manchester Homecare Branch on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Premier Care Limited - Trafford & Manchester Homecare Branch

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 carried out by two inspectors. Three Expert by Experiences made telephone calls to people receiving support from Premier Homecare and their families. 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
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 not a registered manager in post. A new manager had been in post for approximately 4 weeks and had submitted an application to register. We are currently assessing this

application.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 January and ended on 7 February. We visited the location's office on 23 & 24 January.

What we did before 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
We spoke with 10 members of office staff, including the manager, the medicines coordinator and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records, including 7 people's care records and multiple medicines records. We looked at 3 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including quality assurance were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Three Experts by Experience spoke with 48 people who received a service or relatives by telephone. We also spoke with 12 members of care staff by telephone. We received feedback from 1 health and social care professional. We looked at further quality assurance documents, surveys and incident reports.

Inadequate

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. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Approximately 100 care plans were out of date. These were planned to be reviewed annually or if there were any changes in people's support needs. We could not be assured that risks related to people's care had been updated sufficiently. Upon alerting the manager to this concern additional resources were put in place to ensure they were all reviewed by the end of the inspection.
● Assessments had not been implemented correctly. For example, one person required support with PEG (percutaneous endoscopic gastronomy) feeding and required trained staff to manage this type of care. Care plans lacked sufficient detail to guide staff clearly and staff had not been trained until concerns had been raised, about poor care, prior to the inspection. At the time of the inspection, weekend staff, still lacked the confidence to provide the care and the manager had arranged further training to support staff.

There was a failure to robustly assess the risks relating 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.

● An assessment of the environmental risks within each home was completed, for example, lighting and access to the property.

Using medicines safely
● Medicines were not managed safely. Good practice guidance was not followed and effective systems were not in place to ensure medicines were given as prescribed and accurate records were made.
● Records about medicines were not always accurate and could not show that people were given their medicines as prescribed because some staff did not have access to the new electronic system.
● Care plans were not up to date and people's care plans lacked detail about the medicines they were prescribed so they were unable to determine the support people needed for each of their medicines.
● No arrangements were made to identify and administer medicines that needed to be given at specific times, especially with regard to food, which meant they may not work properly.

● When medicines were prescribed to be given "when required" or with a choice of dose there was limited or no information for staff to follow which meant they may not be given safely.
● Some care staff who administered medicines had not had their competency assessed to ensure they had the necessary skills and knowledge to give the medicines support asked of them.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence people were harmed at the time of the inspection, however, unsafe management of medicines placed people at increased risk of harm. This demonstrated a breach of regulation 12 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 were not always safeguarded from the risk of abuse.
● The provider's systems to recognise and take action, on poor practice was not always effective. We could not be assured these had always been reported to the local authority safeguarding team or to the Care Quality Commission.
● There had not been a consistent approach to learning lessons since the last inspection. Staff told us, "When families raised concerns the previous manager would brush issues under the carpet. Including issues related to short or late visits or poor care". The culture of the service prior to the new manager had not focused on opportunities to learn and for this reason opportunities were missed.
● Carers had not followed the safeguarding policy when someone was refusing care. Senior staff had also not escalated appropriately in line with their safeguarding policy. Actions were taken by the manager to communicate staff responsibilities in response to this incident.
● Staff we spoke to had received safeguarding training and understood the signs of abuse and how to raise concerns if they needed to. However, refresher training for staff was out of date and many staff had not received refresher training for over 2 years according to the training matrix provided. Staff had access to a whistle-blower policy to support them with raising concerns.

The provider did not have robust systems and processes to enable them to identify where quality and safety were being compromised and did not respond without delay. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

● There had been a recent improvement since the new manager had started in December 2022 and the office staff had been trained to use a new electronic system to monitor incidents, accidents, safeguarding and complaints. Staff now received a prompt after every home visit and the new manager had been proactive in reporting and managing any concerns.

Staffing and recruitment
● The call monitoring system was ineffective. Oversight by senior staff had not ensured people received their visits on time and for the full duration. This was unsafe as we could not be assured people were receiving their care in line with their care plan.
● Of the 48 people and relatives we spoke with, 21 had concerns about the time and duration of calls and agency staff not providing the same level of care. This had a negative impact on people's wellbeing, personal care, moving and handling, food and drink and medication arrangements. People told us, "The timing of the carers visits is never good, and I never know who is coming" and "Yes, I have had a late call today.2 to 3 hours late, which has an impact as I take my medication in the morning".
● We saw numerous examples in carer visit schedules where 30 to 45 minutes calls were completed in less than 15 minutes. The staff visit schedules for January 2023 did not have sufficient time for staff to travel inbetween calls. There were also instances where carers visits overlapped which meant they needed to be in

two places at once.
● There was a high use of agency staff. People told us agency staff did not know people's needs and the dissatisfaction expressed by people at the last inspection was still a key issue. People told us, "I am not happy because they send me agency staff who have no idea who I am or what to do for me" and "I now get a variety of agency staff who are next to useless. Not trained or knowledgeable about my support needs at all".

Effective 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 breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives were complimentary about the permanent Premier Homecare care staff. People told us "Carers who come give the impression they care and they will do their best for me" and "Delighted with the care family member gets."
● Staff were recruited safely and had the appropriate pre-employment checks in place before employment commenced. Issues for follow up were provided to the manager including the need to for identification to be up to date and car insurance to be the correct type.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider's quality assurance system had not been robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Shortfalls in relation to care reviews, staff spot checks, supervision meetings and team meetings had not taken place as planned.
- This also meant observations of staff using PPE or administering medicines had not been completed consistently since the last inspection.
- As reported in the safe domain approximately 100 care plans had not been reviewed. Risk assessments and medicines records lacked detail. The care plans had been reviewed by the end of the inspection.
- There had been no effective system for auditing in place and this was still being developed during the inspection.
- Governance processes did not identify shortfalls found during the inspection. For example, medicine audits were either not routinely completed or were not effective at identifying shortfalls. Without regular quality assurance processes, shortfalls could not be shared, addressed and learned from.
- As reported in the safe domain systems to manage safeguarding had not been effective.
- There were concerns about medicines records and shortfalls in systems used to monitor and improve this area. A new electronic medicine administration record (emar) system had been introduced but had not been successfully embedded yet.
- The provider was aware the service was not performing and their quality team completed an action plan by the end of the inspection to address the identified shortfalls.

The quality assurance system was not robust. This placed people at risk of harm and was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service had not been well led. Management arrangements and quality assurance systems had not been effective since the last inspection. The previous registered manager had left in December 2022 and a new manager had been in post for 4 weeks.
● As reported in the safe domain some people had a negative experience due to the lateness and short duration of calls and the impact of agency staff who did not know their needs. Other people with regular staff had a more positive experience. The feedback we received was divided between these two groups.
● The provider quality team carried out a recent survey in November 2022 with a response rate of 31%. The feedback was mostly positive.
● We also received mixed feedback from staff. Some were positive and felt valued by the service and others stated there were no spot checks, supervisions and team meetings. They also raised concerns about a lack of travel time between calls and poor support from the office and management. One staff member told us, "No spot checks made, although 1 staff had had a spot check after your visit, the 2nd one in 5 years."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The new manager had demonstrated an open and honest approach and was clear about the requirements of the duty of candour and had notified the CQC and safeguarding teams of any accidents and incidents as appropriate.

Working in partnership with others
● The manager met monthly with the lead social worker for the areas they operated in. They discussed any issues that had been raised by the social work teams and the registered manager could alert the social workers to any changes in people's needs that needed to be re-assessed.
● The manager was meeting regularly with the Local Authority quality team to address the shortfalls identified by the providers quality team in October 2022.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure safe systems for the management and administration of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance system was not robust. Effective 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.

The enforcement action we took:

Warning Notice