Premier Care Limited

Premier Care Limited - Salford Homecare Branch

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
Premier Care – Salford Homecare Branch is a domiciliary care service who provide care and support to people living in their own accommodation within the Salford area.

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 inspection 408 people were being supported by the service, however, only 277 received personal care.

People's experience of using this service and what we found
We found improvements were required with medicines management, management of people's care visits, governance systems and the timeliness with which actions were addressed.

People provided mixed feedback about the timing and duration of care visits. Concerns were reported with inconsistency of visit times, late visits, staff being rushed and not remaining for the planned duration of each visit. As a result, not all people we spoke with felt safe, however, the majority of people spoke positively about the care staff who visited, telling us they were, "Kind" and "Friendly." People's medicines were not managed safely. We identified issues with record keeping, administration and monitoring of people's medicines. Risks to people had been assessed and included in people's care plans. Staff had received training in the use of equipment, such as hoists, to ensure they could provide safe care. Staff had access to personal protective equipment and provided with guidance around the management of COVID-19.

The provider used a range of systems and processes to assess the quality and safety of care delivery. However, these had not consistently identified the concerns we found on inspection or where issues had been noted, action had not always been taken timely. People's views and opinions about their care and support had been gathered through bi-annual surveys, care plan reviews and spot checks. Staff meetings had been put on hold due to the COVID-19 pandemic, instead the provider had used emails, telephone calls and electronic messaging to communicate. Staff told us they were happy with this.

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 December 2017).

Why we inspected
We received concerns in relation to medicines management, rota management, late and missed calls and staff competency with using equipment, such as hoists. 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 Premier Care -Salford Homecare Branch 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to safe care and treatment, specifically the management of medicines.

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

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 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.

Premier Care Limited - Salford Homecare Branch

Detailed findings

Background to this 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 team consisted of an inspector, a medicines inspector and three Experts by Experience, who completed telephone interviews with people and relatives. 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.

The service had a manager registered with the Care Quality Commission, although their registration was for the previous location they worked at for Premier Care. They had applied to transfer their registration to the Salford Homecare Branch, and this was being processed at the time of inspection.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was to provide time for the service to gain consent from people and relatives for us to contact them to ask questions about the care and support provided.

Inspection activity started on 4 May 2021 and ended on 14 May 2021. We visited the office location on 6 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications sent to us by the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with the manager, a company director, head of governance, the medicines compliance officer. We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, audits and policies and procedures were reviewed.

After the inspection
We spoke with 16 people who used the service and 11 relatives about their experience of the care and support provided. We also spoke with 10 staff about their experience of working for the service. We also sent out nine questionnaires to staff who had requested to be contacted via email rather than telephone and received two responses.

We continued to seek clarification from the provider to validate evidence found. We looked at call monitoring data, call alert data (when calls are not completed at the planned time), additional medicines records and quality assurance records. We also clarified the number of people in receipt of regulated activity, as the initial figure reported to us was incorrect.

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.

Using medicines safely

- Medicines were not managed safely.
- Medicine administration records (MARs) were not accurate, despite the checking system in place. The service had not always sought a current list of medicines from the person's GP to use when creating MARs, which had led to errors.
- Care plans did not accurately detail the support people required with their medicines. Where family shared medicines responsibility, care plans were not clear how this would be managed.
- Controlled drugs were not managed safely. Records to monitor stock levels were not in place and staff had not consistently documented if these medicines had been given or at what time, to ensure enough gap was left before the next dose.
- Inconsistency in call times meant the gap between visits did not always support the safe administration of time sensitive medicines.

We found no evidence that people had been harmed, however, systems and processes in place to manage medicines were not robust. This placed people at risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Mixed feedback was provided by people, relatives and staff regarding the management of care visits. Concerns reported included late visits, staff being rushed and not staying for the allocated time. Comments included, "Timekeeping is really bad, sometimes too late, sometimes too early. They [staff] seem quite rushed" and "I was expecting a carer at 9am this morning, it's now 11am. I've not had a call to say they will be late."
- Electronic call monitoring data confirmed people's visit times did not always occur as scheduled. When staff were running 30 minutes or more late this triggered an alert on the services systems. Monthly alert data from January to April 2021 showed over 40 percent of visits had been at least 30 minutes late each month. The service's target was 10 percent.
- Work was underway to reorganise staff rotas to drive improvements with visit times. However, rotas viewed showed minimal travel time was allocated between visits and at times, no travel time was factored in, which meant unless staff left a visit early, they would be late for their next one.

We found no evidence that people had been harmed, however, visit times were inconsistent, staff did not always stay the allocated time and the formulation of rotas was not robust. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Pre-employment checks were completed to ensure applicants were of suitable character to work with vulnerable people. This included completing checks with the Disclosure and Barring Service and seeking references from previous employers.

Systems and processes to safeguard people from the risk of abuse

● People and relatives provided varied feedback about whether safe care was provided. Comments included, "I do feel safe when they come on time or let me know they will be late", "I'm happy in terms of safety, the girls are great" and "No, I don't think [relative] is safe. Carers don't stay for allocated time, [relative) doesn't always get their medication correctly or support to eat & drink enough."

● Staff confirmed they had received training in how to identify and report abuse and stated they would report any issues to the office.

● Safeguarding concerns had been clearly documented with a log used to record what had occurred, the action taken and outcomes.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks to people had been assessed and documented within care files.

● A number of standardised risk assessments had been completed for each person covering areas such as environmental risks, staff safety, infection control and use of equipment. Where people had any specific needs, individual risk assessments had been completed.

● Staff confirmed they had received training and support to use any equipment in place, such as a hoist and felt confident in doing so.

● Systems were in place to log and monitor accidents, incidents and safeguarding. Analysis had been completed to look for patterns and trends, to help prevent a reoccurrence.

● Meetings had been held with staff where concerns had been identified or an incident had occurred, to reflect on what had happened and improve care and support moving forwards

Preventing and controlling infection

● Infection control policies and procedures were in place and up to date.

● Staff had access to personal protective equipment and had been provided with guidance on how this should be used.

● A specific training session related to COVID-19 had been provided, however, the service's training matrix showed only 70% of staff had completed this and a large proportion had only done so since January 2021. However, we saw additional COVID-19 training videos and/or information had been sent to staff on a monthly basis and an assessment of their knowledge completed.

● A weekly staff testing regime was in place, however, as staff tested themselves at home and only reported positive results to the office, the provider was unable to evidence testing had been completed consistently.

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; Continuous learning and improving care

- The provider and manager used a range of audits and monitoring systems to assess the quality and performance of service delivery. Auditing of areas including care visits, continuity of care, complaints, safeguarding, training, medicines and care documentation had been completed on a monthly basis.
- The registered manager assessed service delivery against a range of key performance indicators (KPI's) each month. This data was used by the provider to support their auditing process.
- The service had two separate action plans in place. One had been created in conjunction with the local authority, to address issues identified through safeguarding investigations and meetings with the provider. The second was largely based on the outcome of an externally completed compliance audit.
- Despite the governance systems in place, the issues we found on inspection with medicines, call and rota management had either not been identified or it was not clear what action was being taken to address any shortfalls.

We found no evidence that people had been harmed, however, governance systems were not robust enough to ensure issues with service delivery were either identified or addressed timely. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The majority of people and relatives we spoke with could not recall being asked for their views about the care and support provided. However, a telephone survey had been completed in November 2020 during which 254 people had been asked for their views. Of these 254, only 12 had raised any concerns. The provider had documented what action had been taken to address the concerns raised.
- The provider's policy specified people would receive a review, spot check or other contact every three months. Reviews of care files and KPI data, showed spot checks and care reviews had been completed regularly, however, it was not clear this had been done as frequently as agreed and with each person using the service.
- People, relatives and staff identified poor communication as being a key issue with the service. Comments included, "I asked the office about changing my calls, but nothing happened. I phoned the office and was

told they had forgotten", "The girls are great, biggest fault is lack of communication from the office" and "It's difficult to get through to the office, then there's no follow up to calls we've made to update us on what is happening."

● During interview the manager confirmed, "Communication is our biggest challenge." We saw action was being taken to address this.

● The current manager was reported to have made a positive impact since moving to the service. Comments from staff and people included, "Since [manager] took over things are 100% better. They are slowly sorting problems" and "I think management has changed. They do seem a bit better recently."

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 manager and provider were aware of their responsibility regarding duty of candour. Duty of candour ensures providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment.

● The manager had started to engage more proactively with families, to address issues and concerns. The impact of this had been identified by the local authority, who had noted a reduction in issues being reported directly to them. However, as already stated improvement in communication was needed, to ensure people were responded to timely and consistently.

Working in partnership with others

● The provider and manager were working closely with the local authority, with regular meetings held to identify and discuss shortfalls or concerns and how these would be addressed.

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 We found no evidence that people had been harmed, however, call times were inconsistent, staff did not always stay the allocated time and the formulation of rotas was not robust.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed, however, governance systems were not robust enough to ensure issues with service delivery were either identified or addressed timely.

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 We found no evidence that people had been harmed, however, systems and processes in place to manage medicines were not robust. This placed people at risk.

The enforcement action we took:

We issued a warning notice regarding regulation 12 (safe care and treatment).