Premier Care Limited

Premier Care Limited - Trafford & Manchester Homecare Branch

Inspection report

Ground Floor, 906 Chester Road
Manchester
Lancashire
M32 0PA

Tel: 01618644205
Website: www.prem-care.co.uk

Date of inspection visit:
19 November 2018
21 November 2018
22 November 2018
26 November 2018

Date of publication:
06 March 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Premier Care Limited – Trafford and Manchester Homecare Branch is a large domiciliary care agency. The service provides care and support to primarily older adults living in their own homes in the Manchester and Trafford areas of Greater Manchester.

People's experience of using this service:
Most people using the service told us they were satisfied with the service they received. People were usually supported by consistent teams of staff who knew them and understood their needs and preferences. During our home visits we observed positive, respectful and professional interactions from the staff providing support to the people we visited.

People told us care staff were often late, although they did not feel this had a significant impact on the care they received. The provider monitored staff timeliness through the use of electronic call monitoring. This showed calls were in most instances attended within the provider's 35-minute tolerance. Staff were not always given time on the rota to travel between calls, which meant it was inevitable in some cases that they would be late.

Medicines were not managed safely, and there had been few improvements in this area since our last inspection. There were issues with the records kept, planning how people would receive their medicines and the procedures staff followed. People were at risk of not receiving their medicines as prescribed, and the provider's monitoring of the safe administration of medicines was not robust. The provider had notified us of six medicines errors that they had deemed to be safeguarding concerns since our last inspection.

Most people felt the staff supporting them were competent. Whilst staff were generally satisfied with the standard training they received, there was a lack of in-depth training in relation to topics such as specific health conditions, diabetes and dementia.

Whilst the provider had carried out necessary pre-employment checks, we found shortfalls in their staff recruitment processes. Some staff had gaps in their employment histories without a recorded explanation. Several staff had been recruited despite not meeting the provider's score thresholds for the interview process. Where this was the case, there was no recorded justification of the decision to recruit the applicant, nor details about any additional support or checks that would be carried out to ensure those staff had the necessary skills to carry out their duties.

Whilst care staff we spoke with understood people's care needs, we found this information was not always reflected in people's care plans. Assessments were heavily based on tick-lists with little further information given to staff about how to meet people's identified needs. We found instances where significant information relating to the care people needed, and potential risks to their wellbeing had not been recorded in their support plans. Office based staff were also unaware of these details in some instances.

Whilst staff had recorded information about people's social histories, there was very little information in care plans about people's preferences, including food preferences, how they received their care, or the gender of staff that provided their support. This would make it more difficult to provide consistent care that was person-centred and met people's needs.

People received an annual quality assurance visit and review of their service. People told us they felt involved in decisions about their care. The provider sought feedback from people using the service and people told us they were confident to provide honest feedback.

The provider was not operating robust procedures to monitor the safety of the service, or learn lessons when things went wrong. The provider aimed for supervisors to audit 20 percent of daily logs and medication records. This meant the majority of these records were not checked, and issues had not always been identified on those that had been checked. There was no overview of accidents people using the service sustained if staff had not observed the actual incident, which limited how effectively the registered manager could monitor whether people might require additional support or referral to another service.

The provider had notified us of nine missed calls since our last inspection. They had investigated the reasons for missed calls and had taken action, such as disciplinary action against staff. However, there was no clear overview of missed calls or apparent monitoring of trends,

Premier Care - Trafford and Manchester Homecare service is a large domiciliary care agency. The registered manager was supported by four office based care co-ordinators. Tasks such as auditing of daily logs and medication records, and writing care plans was delegated to supervisors who worked primarily 'in the field'. We found office based staff did not always have a clear picture of the support people were receiving. We also found information we requested was not always readily available.

Rating at last inspection:
We last inspected this service on 12 and 13 September 2017 when we rated the service requires improvement. The report was published on 21 November 2017. This is the third consecutive time the service has been rated requires improvement.

Why we inspected:
This was a planned comprehensive inspection to follow-up our last inspection when we rated the service requires improvement. Following our last inspection, we asked the provider to complete an action plan telling us how they would become compliant with the two breaches of regulations we identified relating to good governance and safe care and treatment.

Enforcement:
We are considering options in relation to enforcement action. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to the end section of reports after any representations and appeals have been concluded.

Follow up:
• We identified breaches of the regulations relating to good governance, employment of fit and proper persons and safe care and treatment. We will request an action plan from the provider to tell us how they plan to address the concerns identified at this inspection, and make improvements to ensure the service is rated at least good at future inspections.
• We will request that the provider meets with us and commissioners of the service to discuss how they will make improvements.

• We will continue to monitor the service.

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 caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive 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 - 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 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of an adult social care inspector, a bank inspector, an assistant inspector, two medicines inspectors 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:
Premier Care Limited – Trafford and Manchester Homecare Branch (Premier Care) is a large domiciliary care agency. The service provides care and support to primarily older adults living in their own homes in the Manchester and Trafford areas of Greater Manchester.

Not everyone using Premier Care receives support with a regulated activity. The provider is registered to provide the regulated activity 'personal care' from this service. CQC only inspects the service being received by people provided with 'personal care', which includes help with tasks related to personal hygiene and eating. Where people do receive such support, we also take into account any wider social care provided. At the time of our inspection, the service provided support to around 370 people, of whom approximately 245 received support with personal care. The service employed around 135 members of staff.

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
We gave the service three days' notice of the start of the inspection. This was so the registered manager could help us arrange visits to people using the service, and to check the contact list they had provided to us was up-to-date. We carried out the visit to the service's offices unannounced, although the provider was aware we would be visiting that week.

Inspection site visit activity started on 19 November 2018 and ended on 26 November 2018. It included phone calls to people using the service and their relatives, visits to the homes of people using the service and phone calls to staff members. We visited the office location on 21 and 22 November 2018 to see the registered manager and office staff; and to review care records, policies and procedures.

What we did:
Before the inspection we:
• Reviewed the provider information return (PIR) sent to us by the service. 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. The provider sent us their PIR in October 2018.
• Reviewed statutory notifications sent to us by the service. This is information about significant events such as safeguarding, deaths and serious injuries that the provider is required to send us.
• Reviewed any feedback we had received about the service from people using the service, relatives or professionals.
• Sought feedback from community professionals who had experience of the service, Manchester and Trafford local authority quality and contract teams, and the Manchester and Trafford Healthwatch branches. We received responses from both local authorities. Healthwatch told us they had not received any feedback about the service.
• We used this information to help us plan our inspection and make judgements about the service.

During the inspection we:
• Visited eight people in their homes, where we spoke with them, their relatives and care staff (when present).
• Spoke with 11 people using the service and four relatives by phone. We were limited in the number of people we could contact by phone, as the provider had not indicated as requested, who would be able to speak with us on the contact spreadsheet they sent us.
• Reviewed 12 people's care files.
• Looked at 17 people's medicines administration records (MARs).
• Spoke with 24 members of staff, including: The company director, the registered manager, 17 care staff/supervisors, three care co-ordinators, the head of governance and a member of administrative staff.
• Reviewed eight staff member's personnel files and recruitment records.
• Looked at records, including those relating to: training, staff supervision, accidents, daily records of care and policies and procedures.

After the inspection we:
• Requested and received additional information from the registered manager. This included information relating to training and missed calls.
• Requested update on actions they had taken as the result of feedback we gave at the end of our site visit.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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:
• At our last inspection in September 2017 we found the provider was not managing medicines safely. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found ongoing shortfalls in relation to the safe management of medicines, and the provider remains in breach of this regulation.
• Since our last inspection the provider and/or the local authority had told us about six safeguarding issues relating to the safe management of medicines. This included cases where staff had not administered people the correct medicines or had not administered medicines at all. In some cases neither the care staff nor the provider had identified these errors.
• There were shortfalls in the records staff kept about medicines. The medicines administration records (MARs) we reviewed did not contain details such as people's allergies or full prescribing instructions. Staff had hand-written MARs and there was no routine system in place to check the information they recorded was correct.
• We found one instance where staff had recorded that they had administered more than the prescribed amount of a person's medicines. We concluded in this case that this was a clerical error rather than medicines administration error. In other instances, we saw staff had not signed to show medicines had been administered as prescribed.
• Some people were prescribed topical medicines. Staff were not always recording when they supported people to apply topical medicines, and there were not always directions in place to enable staff to understand when and where to apply cream medicines.
• Some people were prescribed medicines that needed to be administered at specific times to ensure they worked effectively. There were no systems in place to ensure people received these medicines at the correct time, and staff told us they administered them at the same time as their other prescribed medicines.
• During our home visits we found staff left one person's medicine for them to take at a later time. This practice was not detailed in their care plan and had not been risk assessed. This was also contrary to the provider's policy.
• We saw the medicines of another person we visited who lived with their family were not stored safely. Their care plan indicated they had short-term memory loss and dementia, and were at risk because 'they might not remember taking their tablets'. However, we found their medicines were stored openly in the kitchen where the person had access to them. We made the registered manager aware of these concerns.
• We found some people were prescribed 'when required' (PRN medicines). None of the people whose medicines we reviewed had PRN protocols in place, and information was not always clearly recorded about who was responsible for administering these medicines. Some staff told us they did not administer medicines that did not come in pre-packaged blister packs. Neither the provider's policy, nor people's care

plans clarified whether people could be administered when required medicines by staff. PRN protocols inform staff when they should administer these medicines, and what their intended effect should be. This meant there was a risk people would not receive prescribed medicines when they needed them.
• Since our last inspection, the provider had added a prompt for supervisors to check the completion of MARs during spot-check visits. Despite this improvement we found ongoing issues in relation to the monitoring of the safe management of medicines.
• At our last inspection we found none of the MARs we reviewed had been audited. Following this, the provider introduced a system whereby supervisors aimed to check 20 percent of the records returned to the office monthly. This meant the majority of MARs returned to the office each month would not be checked. We also found that staff had not always identified errors on the records they had checked.

The issues above were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations in relation to the safe management of medicines.

Staffing and recruitment:
• The provider had a system in place to help them work out how many staff they needed. The registered manager monitored staffing levels through weekly reports.
• Since our last inspection in September 2017, the provider had sent us nine safeguarding notifications that related to missed calls. During the inspection we saw the registered manager had investigated missed calls through either the complaints, or safeguarding processes. In some cases, this resulted in the provider taking disciplinary actions against staff, or identifying lessons learned such as 'office team to communicate effectively'.
• The provider used electronic call monitoring (ECM) that was programmed to alert office based staff if calls were more than 35 minutes late. We asked the provider and registered manager why this system had not been effective in the instances of the missed calls. , as it was not apparent that they had considered this when carrying out investigations. After the inspection they sent us copies of emails that demonstrated the head of governance and registered manager had considered the reasons the ECM had not always worked as intended. However, this was not clearly recorded in the investigation reports and records held at the service.

• People told us their care staff were often late, although we could not be clear from their reports how late staff were, or how often this was. In general, people were accepting of these delays and did not feel they had a significant impact on their care.
• The provider showed us electronic call monitoring data from the previous week that showed the majority (97.2%) of calls were within the 35-minute tolerance they set, and no calls had been delayed by more than 45 minutes.
• We asked the registered manager if they could show us call monitoring information for people who required calls that were 'time critical'. This means calls where it would be important that staff arrived promptly due to those people being at a higher risk of potential harm if they did not receive food or medicines at prescribed times for example. The registered manager told us they did not 'really have any' time critical calls any more. Following the inspection, the provider sent us evidence that some time critical calls were identified on their call monitoring system. However, we identified three people whose calls it would be important for staff to attend in a timely way due to them receiving time-critical medicines, or because they were diabetic and may need to eat at particular times of the day. None of these three people were identified on the provider's list of time critical calls. This showed processes to ensure that unforeseen delays did not negatively impact on people's safety and welfare were not consistently followed.
• Staff told us they were not allocated travel time on the rotas, which affected their timeliness. The registered manager told us travel time should be allocated on the rotas, and told us staff generally attended calls in close proximity. However, we saw several instances where staff had not been given any travel time between calls on their rotas. We looked at a sample of travel times between calls where no travel time had been

allocated on the rota. The average (mean) travel time for these nine calls as allocated on the rotas was just under six minutes.
• There were short-falls in staff recruitment procedures in place to ensure staff employed were of suitable character and had the necessary skills and experience for the role. The provider had undertaken required checks, such as a disclosure and barring service (DBS) check and they had sought proof of identity. A DBS check provides information on whether the applicant has any previous convictions or, dependent on the level of the check, is barred from working with vulnerable people.
• Providers are required to obtain a full employment history for staff they recruit. However, there were unexplained gaps in the employment history of two of the eight staff members' personnel files we reviewed
• Two staff members had not reached the providers' 'pass mark' for the interview part of their application, yet had been employed regardless. The staff member formerly taking a lead role in relation to recruitment told us there was a pass mark for the written assessment part of staff member's applications. A third member of staff had not reached the level required to pass this part. The provider later told us there was no pass mark for this part of the application process.
• We spoke with staff responsible for recruitment who told us they could get 'a feel' for whether someone was suitable for the role during interview, even if they did not meet the pass marks. However, there had been no rationale recorded, nor details of any further support that would be offered, or checks that would be made of these staff members to ensure they were suitable for the role.

This was a breach of Regulation 19(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:
• At our last inspection in September 2017 we found the provider was not adequately managing risks to people's health, safety and wellbeing. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made adequate improvements, and remains in breach of this regulation.
• People had a standard format care plan/risk assessment document in place. This included standard tick-lists to indicate whether people had certain health conditions, difficulties swallowing, were at risk of skin breakdown, were 'prone to wandering' or were 'at risk of self-harm' for example.
• Staff had assessed the safety of people's home environments and any further actions they might need to take to ensure risks to staff and people using the service were minimised. Risk assessments were in place to help ensure staff could safely support people who needed help mobilising or transferring using the correct equipment in the right way.
• Whilst some care plans contained details about how staff should mitigate identified risks, this was not consistent. We saw information such as social services assessments, and ticked boxes in people's assessments that indicated three people required soft diets, or were at risk of choking due to swallowing difficulties. In two cases, there was no information in the care plans or risk assessments about how staff should reduce any potential risk of choking or aspiration. The provider told us staff did not support these people with eating and drinking, though this was not clear from their care plans.
• One person who received a significant amount of support from the service was indicated by the tick lists to have epilepsy. Whilst staff told us they had not had any recent seizures, there was no further mention of epilepsy in the care plans and risk assessments, including how staff should respond to, record or monitor any seizures. In another case, we were aware that a person had bedrails on their bed that staff had to put up/down when they provided care. Again, there was no reference to this in any of this person's care plans or risk assessment. Although staff working with these individuals were aware of the care these people required in these areas, office staff were not aware of these risks or how staff managed them. This demonstrated the provider's risk assessment procedures were not robust. We asked the registered manager to review these people's assessments to ensure they contained the required information.

• Staff understood how they should respond in the event of someone having an accident and sustaining a potential injury.
• Procedures for monitoring accidents, incidents and trends were not robust. As at our previous inspection in September 2017, we found there were no recorded accidents/incidents relating to people using the service. The provider's policy for reporting and recording accidents/incidents sustained by people using the service was unclear about what staff should report and how.
• The registered manager told us staff would only record accidents and incidents on an accident/incident form if they had occurred whilst they were providing support. They told us staff would not fill in these forms, if for example, they arrived at someone's home to find they had sustained a fall. Staff we spoke with confirmed this, and told us they would make a note in the person's daily records of the incident, and in some circumstances, call the office. However, the registered manager did not maintain a separate record of these events.
• This meant there was limited oversight of accidents, and an increased risk that trends in accidents would go unnoticed. This could mean that staff might not identify reasonable steps to reduce potential risks to people using the service, or make referrals to other professionals when needed.

The issues outlined above in relation to risk assessment and risk management constituted an ongoing breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not adequately assessing risks to people's health, safety and welfare.

Systems and processes:
• People told us they felt safe with their care staff. They told us staff always carried identification, wore a uniform and left their house secure.
• Staff had identified potential safeguarding concerns that the registered manager had notified to both the CQC and local authority as required.
• The registered manager kept a record of any safeguarding concerns raised. We saw they tracked the outcome of any investigations carried out internally or by the local authority safeguarding team.
• Staff were aware of how to identify and report any potential safeguarding concerns they might have.
• We saw there were processes in place for recording any financial transactions care staff made on behalf of people they supported. Staff told us they would always make a record of any purchases, and retain receipts.

Preventing and controlling infection:
• People told us staff used personal protective equipment (PPE) such as aprons and gloves, when needed, and kept their homes clean.
• During our home visits, we saw staff had PPE with them and they kept people's kitchen areas clean when preparing food.
• Staff understood their roles and responsibilities in relation to infection control and hygiene. When asked how they helped prevent the spread of infection, one staff member told us, "I do the job professionally, wear gloves and make sure food is well kept for example. I keep areas tidy and clean and change gloves between tasks."
• The registered manager had encouraged staff to get a flu vaccination from their GP or pharmacist.

Learning lessons when things go wrong:
• The registered manager kept a log of safeguarding concerns raised. This included a column that prompted them to consider any 'lessons learned' as a result of the incident. Lessons learned that the registered manager had recorded included actions such as revising procedures for reviewing referral information, re-iteration of the 'no-access procedure' to care staff, and reminders to care staff about the correct procedures they should follow.
• Whilst there was some evidence of lessons learned, this was limited in depth and scope. There was the

potential that the opportunity to learn lessons was missed in some instances. As previously discussed, there was a risk that learning from accidents and incidents would not take place due to limitations in the agency's recording and monitoring procedures.

• The service did not have robust procedures in place for learning lessons from incidents involving medicines errors. We raised concerns in relation to the safe management of medicines at our last inspection but did not find significant changes had been made to the way the provider managed medicines despite further incidents having occurred. We had also received similar concerns from the local authority safeguarding team about how an investigation into a medicines error had not been robust and did not demonstrate lessons had been learned, nor that appropriate steps had been taken to prevent a similar incident happening again.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff skills, knowledge and experience:
• Most people we spoke with told us they were confident that care staff understood, and were able to meet their needs. The one exception was a relative who told us they did not feel staff understood their family member's health condition. We found staff had not received any specific training in relation to this health condition.
• Staff completed training during a three-day induction that was provided by an in-house trainer in person. This was followed by annual 'refresher' training. Most staff felt this training was adequate to equip them with the skills and knowledge they needed to meet people's needs.
• However, training covering specific conditions people had including dementia, Parkinson's and diabetes was limited. All three staff we asked told us they had not received training in these areas. Three staff members we spoke with also told us they had requested additional training in topics including mental health and dementia. Two of these staff members told us there had been no follow-up of their requests for this training.
• Some people using the service were living with dementia. The registered manager told us dementia training was included as part of the staff inductions and provided evidence of this. However, the care staff we asked told us they had received no training in dementia. This indicated this was not a prominent focus of their training, that refresher training was required, or that the training had not been effective.

• The provider aimed to give staff six 'support sessions' per year. This consisted of a mix of supervisions, competency/spot-checks and an annual appraisal. We saw these sessions had taken place as planned.
• Staff practice was observed during spot-checks. The supervisor considered aspects of people's care including the timeliness of staff, completion of records and administration of medicines. The supervisor provided staff with feedback in relation to any improvements required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Most staff told us they found people's care plans contained sufficient information to allow them to understand what support that person needed. They told us that if they found care plans were not sufficiently detailed, they would liaise with other people involved in that person's care, such as family or other staff members.
• People had a standard format care plan and risk assessment document in place. We found these were primarily based on 'tick-lists' to indicate people's needs. There was in most cases, limited additional detail recorded to guide staff how to meet people's needs and preferences.
• We were not always able to get a clear picture of people's needs or the support they required from their

care plans. For example, it was unclear why one person received support overnight, or what support they needed. Another person's assessments did not make reference to the fact they had bed-rails in place. A third person's care plans made no reference to specialist equipment staff told us they had to support their independence and day to day living. Care plans were not always updated promptly to reflect changes in the support staff provided.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not carried out adequate assessment of people's needs.

Staff providing consistent, effective, timely care within and across organisations; Supporting people to live healthier lives, access healthcare services and support:
• Prior to our inspection, social services and the provider made us aware of an incident where the service had not started a person's care package when social services had requested. This put them at risk of harm. The registered manager had addressed this issue by revising procedures for how care co-ordinators reviewed and handled communication from service commissioners.
• We asked a care co-ordinator how changes to people's planned care would be made if their needs had changed. They told us they would contact social services to request that a social worker review the social services care plan, and then Premier Care would update their own care plans.
• People told us they were confident that staff would support them to contact a doctor or other health professional if they noticed a decline in their health. We saw evidence in people's daily logs that staff had contacted professionals including GP's, community psychiatric nurses (CPNs), district nurses and the 111 service.
• However, this information was not clearly recorded in any separate log, which meant there was a risk that office based staff would not be aware of advice provided, and care plans would not be updated to reflect a change in needs or support provided. For example, one person's needs in relation to eating and drinking had changed and the update was not reflected in their care plan. It was also unclear who advised the changes due to the lack of clear records. Staff told us they had recently started recording dietary intake for another person on the advice of district nurses. However, they were not able to tell us if, or where this information would be recorded.

Supporting people to eat and drink enough with choice in a balanced diet:
• Staff supported some people using the service to prepare meals or eat and drink. Information about the support they required to eat and drink, and who was responsible for providing this support was not always clear within care plans. However, we saw such information was recorded in the electronic notes accessible to care staff.
• People told us staff knew their preferences in relation to food and drinks, which was also apparent from our conversations with staff. However, none of the care plans we looked at contained information about people's likes and dislikes in relation to food and drink. There was no information in people's care plans about how staff should meet any dietary requirements such as for people who had diabetes.
• During our visits to people's homes we saw staff prepared food that people's relatives had bought for them. Staff asked people's preferences when preparing their meals or drinks.
• One person told us, "There's no problem with the food they [staff] give me. If I'm not hungry they'll leave me something I can heat up later." Whilst staff ensured people had something to drink during the calls we observed, in one case, staff did not leave a drink within a person's reach when they left. This person would have been unable to get a drink independently.

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 Act 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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.
• At our last inspection in September 2017 we found there were capacity assessments on people's care files that were not decision specific. Some people's consent forms had been signed by others without legal authority. We recommended the provider reviewed and implemented guidance in relation to the Mental Capacity Act.
• The provider had reviewed their consent plan format since the last inspection. This now provided options for a person's representative (such as a family member) to sign the form as someone consulted as part of a best-interests decision, or on the verbal request of the person using the service.
• We saw some people still had the old format consent forms in place where it appeared that relatives without legal authority to take decisions on behalf of their family member had signed consent forms. The provider told us they aimed to replace the old format forms at annual reviews. This meant everyone should have a new form in place by April 2019.
• Capacity assessments had been completed when people started using the service. Whilst it remained unclear in some instances, what the decision was that the capacity assessments related to, the format of people's care files suggested the decision related to people being able to consent to the provision of their planned care, or their ability to sign their consent forms.
• When speaking with staff, we became aware of potentially restrictive practices followed in relation to one person using the service. The registered manager and care co-ordinator were unaware of the practice followed or the reasons for it. Staff had completed a capacity assessment for this person that showed they had capacity. However, the information staff provided us with meant it would have been reasonable to question this person's capacity about certain decisions and in certain circumstances. We asked the registered manager to look into these concerns and consider making a referral to social services for a re-assessment. This also highlighted the lack of quality assessment and review undertaken for this person.
• Other than the potential issue highlighted above, we found staff acted in accordance with the MCA when providing support to people day to day. People we spoke with told us staff always asked for their permission before providing any care and support. One person told us, "They [staff] don't do anything I don't want" and another person said, "They [staff] always tell me what they're going to do. They're very helpful." During our home visits we saw that staff offered people choices, and checked whether people were ready before providing support, when using a hoist for example.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence:
• People felt that staff respected their privacy and dignity. Examples people gave of how staff did this included; taking the opportunity to have a chat, using people's preferred names, paying attention to what people said, and by covering people up when providing personal care.
• The one exception to this related to a relative who told us they had raised concerns about a staff member not respecting their family member's privacy whilst providing personal care. They told us they had requested their family member did not receive support from male care staff and that the provider had responded that this was not always possible due to 'staff shortages'.
• The provider's electronic scheduling systems allowed them to prevent selected staff members from being put on the rota with certain people using the service. This could be done based on their knowledge of people's preferences or other considerations. However, the provider acknowledged they did not ask about, nor record people's preferences in relation to the staff that provided their care. This included people's preferences in relation to the gender of their care staff. This would limit the extent to which the registered manager could take reasonably practicable steps to meet people's preferences in this respect.

• People using the service and their relatives felt staff did what they could to support them to remain independent. People told us staff supported them at a pace they were comfortable with, and they did not feel rushed. One person told us, "My independence isn't a problem; They always let me do what I can do." A relative we spoke with said, "It's difficult for my [relative] to do anything because of their [health condition]… Nevertheless, the carers are patient and keep trying."
• Staff told us they would encourage people to remain mobile and would assist people to complete tasks, such as preparing their meals where they were able to be involved in such activities.
• People were confident that the provider would keep their confidential personal information securely. We saw paper documents at the office were stored in locked cabinets.

• Care plans prompted the staff member carrying out the assessment to consider any needs people had relating to their religion, culture or beliefs.
• The provider told us they used a third party to support their recruitment campaign. They told us this company helped them recruit staff members from harder to reach communities. This would help ensure their workforce was representative of the communities they worked in.

Ensuring people are well treated and supported:
• People were positive about the relationships they developed with their care staff. Comments included, "They [staff] are so good to me", "Our relationship is very good; friendly", "It's a friendly relationship, mostly

with the same carers. We chat and have a laugh."
• During our home visits we observed that care staff treated people compassionately and with kindness and respect. Care staff talked to us about people in a way that showed they knew people well and cared about them.
• Most people told us they received support from a consistent team of staff, although some people told us they would like greater consistency. One relative told us, "We usually see the same carers" and a person using the service said, "We get on quite well, but it's difficult because so many different carers come." Another person told us, "The carers are just very nice. Maybe there are different ones every day, but they're from a pool of only about 10, so you do get to know them."
• Rotas we looked at showed people usually received support from a regular set of four or five care staff. Staff told us they tended to work with the same people regularly, and some staff told us they had worked with the same people consistently for several years, including when packages of care had been transferred to Premier Care from other providers.

Supporting people to express their views and be involved in making decisions about their care:
• People, and when appropriate, their relatives felt involved in, and informed about the care they received. Staff held annual reviews of people's care where they sought feedback about the service people received.
• People told us staff listened to them and respected their wishes. Comments included, "The carers do listen and do what I want: that's not a lot to ask", "My [relative] has [health condition] and communication is difficult. The carers take the time to listen" and "They take time to listen to [relative]".
• People were given a customer guide that contained information about the service when they first started receiving care.
• People, and where appropriate, their representatives had signed to show they had been involved in developing their care plans or had taken part in reviews of their care. The registered manager was aware of local services that could provide lay advocacy support if required.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Personalised care:
• Care plans prompted supervisors to record information about people's social histories, their interests, likes and dislikes. However, this information was often limited, and care plans were not person-centred. Most care plans contained little information about people's preferences in relation to how they received their care, their likes or dislikes.
• There were no recorded details about people's preferences in relation to food and drink or the gender of their care staff in the care plans we reviewed. Whilst we found care staff we spoke with were generally aware of people's preferences, the lack of recorded information would increase the likelihood of care that was not consistent and did not meet people's needs and preferences.
• We found three of seven care files we checked did not have detailed records of how staff should provide people's care in accordance with their preferred routines (or this information was incomplete). Whilst most care plans contained lists of 'tasks' that staff needed to complete during people's calls, in most cases this information was limited in detail and would not support the delivery of person-centred care.
• Care staff had access to electronic information about key tasks required at each call. These records contained basic information such as 'prompt medicines; empty leg bag'. Whilst most staff told us they found care plans contained sufficient information, three staff members told us this was not always the case. One staff member commented, "It's not in the file what should be; It's not as detailed as it should be" and a second staff member told us, "[There is] not always [enough information]. The care plan might just say to assist to wash and dress, which isn't enough, especially if it's the first visit."
• Most care plans contained information about people's social histories and brief details about any current interests they had. This would help staff get to know people and understand their support needs.
• People had received an annual review of their care with a supervisor where their feedback on the service was sought. We saw people, or their representatives had signed to indicate their involvement.
• We asked staff how they provided person-centred care within calls that lasted 15 minutes. Staff and people using the service felt these calls were not of sufficient duration for staff to provide high quality care. The provider told us the local authorities continued to commission 15-minute calls, but that they would not accept 15-minute calls if they included personal care. The provider's monitoring information showed that less than two percent of calls were of 15-minute duration, with most of the calls being 30 minutes long.
• People's care plans identified if they had any disability or sensory impairment that could affect their communication. Most care plans identified any support staff needed to provide to help people understand any information they were given.

Improving care quality in response to complaints or concerns:
• Some people told us they had called the office as care staff had not arrived at the scheduled time. However, no-one we spoke with had felt the need to raise a formal complaint. People told us they would

contact the office if they had any concerns, and would be comfortable doing this.
• The provider had a complaints policy that set out clear expectations and roles in relation to acknowledging, investigating and responding to complaints.
• We saw the provider had carried out investigations in response to any formal complaints raised. Responses to people raising complaints included details of any actions taken to address their concerns, and an apology when appropriate. Responses were provided within a reasonable time-scale, and as set out in the provider's policy.

End of life care and support:
• The registered manager told us no-one the service supported was receiving end of life care.
• Care plans did not contain any details about people's wishes or preferences when approaching the end of their life.
• The registered manager told us they did not think anyone using the service had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place. However, when asked, staff were not clear about if or where such information would be recorded.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

• At our last inspection in September 2017 we found the provider was not meeting requirements in relation to records and monitoring/improving the quality and safety of the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found sufficient improvements had not been made at this inspection, and the provider remained in breach of this regulation.

• The provider commissioned a third party to carry out an audit of the service on their behalf. The last such audit had taken place in October 2018. We saw the provider had introduced a new 'making it happen' plan to help ensure any issues/actions identified through this audit were followed-up.

• The electronic call monitoring/care management system produced automated key performance indicator (KPI) reports. The registered manager reviewed these reports weekly, and annotated them with additional information to help explain any apparent performance issues or identified trends. The KPI reports considered aspects of service delivery including staffing, recruitment, accidents/incidents, missed calls, timeliness of calls and completion of reviews and spot-checks.

• There was limited oversight of long-term trends despite this monitoring. For example, when we requested information on the timeliness of calls, this was provided for the previous week. However, when we asked for information to demonstrate longer-term performance in relation to call timeliness, such as over the past quarter or month, this information was not readily available.

• Whilst the registered manager and provider monitored missed calls through the KPI report, there was no readily available single overview of missed calls. The provider was not able to demonstrate that they had considered common themes or contributors to missed calls that it might be possible for them to address.

• There were ongoing and widespread issues in relation to the safe management of medicines.

• There were ongoing issues in relation to the return and audit of daily logs and medication administration records (MARs). Whilst we found some improvement in this area, we found one person's records had not been returned to the office since 2014.

• The provider aimed for supervisors to audit a 20 percent sample MARs and a 10 percent sample of communication logs. This meant the majority of the records of people's care records were not checked within a given month. We also found that issues we found had not always been identified through the MAR audits.

• The registered manager was not able to demonstrate how they maintained an oversight of the staff members that had completed their induction. However, following the inspection, the provider sent us evidence that their electronic care management system did keep a record of which staff had completed their inductions.

• There were issues in relation to the quality of assessments carried out, and care plans were not person-centred or always reflective of people's current support needs. These issues had not been addressed though the systems such as the annual quality assurance visits and care reviews. Annual reviews and quality assurance audits often contained limited detail.
• The service did not demonstrate that lessons were learned when issues had arisen. There were ongoing issues in relation to the safe management of medicines that the provider had not adequately addressed since our last inspection. There was limited oversight of accidents and incidents due to the recording and reporting procedures. It was also not evident that the provider considered any potential common themes relating to missed calls.

These issues were an on-going breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not operating effective systems to assess and monitor the quality and safety of the service.

• Staff told us they felt they would be treated fairly if they made any mistakes, and felt the culture of the service was open and honest. One staff member told us, "I would just pass on any mistakes I made [to a manager]. You look at the person you are looking after, my priority is to them, not myself and you have to take the consequences. I do think they [premier care] would treat me fairly. A second staff member said, "I think there are a good group if carers. I would report if I thought otherwise."
• The provider had plans in place to introduce a new electronic format care plan, care records and medicines administration record system. They showed us the system that was under development and they told us should soon be ready to 'roll out'.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• There was a registered manager in post as is required as a condition of the provider's registration with CQC. The registered manager had been in post for seven years.
• The registered manager was supported by four care co-ordinators who were primarily office based. A team of 'supervisors' worked mainly delivering care to people, but also had responsibilities in relation to writing care plans and carrying out reviews and audits of records.
• Given that this was a large service supporting around 370 people, we asked a care co-ordinator whether they felt they received sufficient support and resource to carry out their responsibilities. They told us the job could be challenging at times, but felt they received sufficient support.
• Care staff described the purpose of their role as being to; 'provide person-centred care', 'look after people' and 'support people's independence'.
• During the inspection we found information about the service and people using the service was often not forthcoming. For example, care co-ordinators did not always have a clear overview of the support people were receiving. We sent the provider a list of questions in advance of our visit to help us get some key information about the service and the people it provided support to. This was information that should be readily available within a well-led service. However, we had still not received all the requested information by the end of the site visit.
• Some of the provider's policies did not support the delivery of a consistent, professional service. We found some policies needed to be reviewed by the provider as they were not sufficiently detailed or suited to the service. For example, the policy on accident and incident reporting was not explicit about staff responsibilities in relation to reporting and monitoring accidents or incidents involving people who used the service. Another policy stated that people using the service were responsible for calling the office if their care staff did not turn up within 60 minutes. The head of governance acknowledged that this needed to be re-worded, but told us the intention of this part of the policy was to act as an 'extra line of defence' against missed calls. They acknowledged that some of the provider's policies required review.

• The registered manager had submitted statutory notifications to the CQC about allegations of abuse as required. We saw the service's performance rating from their last inspection was displayed prominently in the reception area of their offices.

Engaging and involving people using the service, the public and staff; Working in partnership with others:
• The provider carried out an bi-annual telephone survey with a sample of people using the service. A representative from the provider's head office called people to ask for their opinions about the service. Few issues had been raised, and those that had, had been passed to the registered manager to investigate and act on.
• People we spoke with confirmed they could provide their opinions about the service though both the phone survey, and the quality assurance/review visits they received. People told us they would feel comfortable informing the provider of any concerns they had.
• The provider continued to run 'drop-in' sessions from venues they hired in the local community. Although they told us these events had not been well attended, this provided people with the opportunity to speak with managerial staff in person without having to travel to the local office.

• Although opinions were mixed, the majority of staff we spoke with felt they received adequate support, and thought the service was well run. Comments included, "I am proud of working for premier care. We are very well known in the area and get good feedback from clients and council," "It's not bad," "They [managerial staff] are helpful they will talk things through if you have any problems, if they're busy they do always call you back" and ""Premier Care don't help us. They don't deal with problems."
• Staff attended regular team meetings where they were given information on procedures and the expectations of their managers. Staff told us they were able to voice their opinions at these meetings, although not all staff felt they were listened to.
• There had been no staff survey, which was also flagged in the audit carried out for the provider.
• The director spoke about various ventures that staff at the service were involved in to help support the community in which they worked. This included working with charities and voluntary organisations.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not operating robust procedures to ensure persons employed were of suitable character and had the skills and experience required to undertake their job roles. Some information in relation to persons employed and required under Schedule 3 of the regulated activities regulations was not maintained. Regulation 19(1)(2)(3)

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out adequate assessment of people's needs and preferences. Regulation 9(1)(3)

The enforcement action we took:

We served a warning notice to the provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. The provider was not adequately assessing and managing risks to people's heath, safety and welfare. Regulation 12(1)(2)

The enforcement action we took:

We served a warning notice to the provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective processes to adequately assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:

We served a warning notice to the provider and registered manager.