Premier Care Limited

Premier Care Limited - Trafford & Manchester 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 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

This inspection took place on 12 and 13 September 2017 and was announced.

Premier Care Limited – Trafford and Manchester Homecare Branch (Premier Care) is a large domiciliary care agency. The service provides care and support to adults living in their homes in the Manchester and Trafford areas of Greater Manchester. At the time of our inspection, the service provided care to 340 people and employed 125 members of staff.

We last inspected the service in April 2016 when we rated it requires improvement overall and identified breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, good governance and complaints. At this inspection we found the provider was now meeting the regulations in relation to person-centred care and complaints. However, we found an ongoing breach in relation to good governance and identified a new breach of the regulations in relation to providing safe care and treatment. You can see what action we have told the provider to take at the back of this report. We have also made a recommendation that the provider reviews good practice guidance in relation to implementation of the Mental Capacity Act (2005).

We found people's experiences of the service varied widely. Some people were very happy with the support they received from kind and caring staff and told us they were listened to. However, others reported inconsistencies in the caring approach of staff and felt communication with staff at the service was poor. Some people told us members of care staff they had not seen before were often sent without them first being informed, or the new member of staff introduced.

Since our last inspection, we had received several notifications from the provider of missed and late calls that had affected people's care. People told us they had not had any recent missed calls, but reports around the timeliness of calls varied. The provider told us they aimed to attend all calls within 30 minutes of the allotted time. Their electronic call monitoring system showed the majority of calls were attended on time. Less than 3% of 5,377 calls the week prior to our inspection had been more than 35 minutes early/late.

Records of medication administration were not always clear and we found repeated examples where staff had not signed to show they had administered medicines. The provider did not have an effective system for monitoring the completion of medication records and took ineffective action to follow-up potential medicines errors.

Staff and the provider had identified and reported potential safeguarding issues to the local authority and CQC as required. Staff had received training in safeguarding and safeguarding was also discussed in supervisions and team meetings. The provider had completed investigations as required when this had been requested by the local authority safeguarding teams.

Staff had considered and documented potential risks to people's health and wellbeing. However, we found

these assessments were not always accurate, and there were not always clear plans in place to help staff reduce any risks. For example, one person was indicated as being vulnerable if they left their home and another person was shown as being at risk of pressure sores. However, there was no clear information on how staff should help reduce such risks.

Staff had received a range of training relevant to their job roles and had regular supervisions. Staff told us they felt supported and said they were able to approach the registered manager with any concerns they might have.

We found some people's care files contained consent forms in them that had been signed by relatives. However, there was no evidence the service had considered whether people's relatives had legal authority to provide consent on their family member's behalf.

People told us staff respected their privacy and dignity. Staff supported people to retain their independence, and people reported they were never rushed by staff during their calls.

Records of complaints showed the provider had promptly investigated and responded to formal complaints. People told us they would be confident to raise any concerns with the provider and we saw staff checked people were aware how to raise a complaint during 'spot check' visits. Most people we spoke with told us they had been satisfied with actions taken by the service in response to any concerns, such as not sending the same staff members to them again, although this was not everyone's experience.

Care plans were personalised and contained information on the health and social care support needs people had. People told us staff had talked to them about their preferences for their care and had incorporated this into the care plans. However, we found copies of care plans in the office had not always been kept up to date and did not always reflect the support people were currently receiving.

We received mixed reports from people using the service as to whether there was effective communication with the provider. Some people found office based staff responded promptly to any queries or requests they had. However, other people told us phone calls to the office often went unanswered or were not returned when they had left a message.

Staff were motivated and happy in their job roles. They told us they felt the service was well organised and well run. The staff we spoke with demonstrated caring values.

The service had a registered manager in post who was supported by a team of care co-ordinators who also assumed some management responsibilities. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had sought feedback from people using the service via surveys and telephone interviews. The majority of the feedback received had been positive, and the registered manager had followed up any concerns raised by individuals. However, people told us they had received no feedback on the findings of these surveys that they had regularly completed.

There were few audits in place to monitor the quality and safety of the service. For example, there was no formal medicines audit and we found checks of care records returned to the office were blank on all the documents we looked at. There provider used an external auditor to carry out a twice yearly review of the

service on their behalf. However, we saw they had not acted on a number of concerns identified in these reviews that we found to be ongoing at this inspection.

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 consistently safe.

Medicines were not managed safely. Records of medicines administration were unclear and incomplete. There had been several medicines errors reported to local authority safeguarding teams.

Since our last inspection we continued to receive reports of late calls and missed visits. The provider's call monitoring system showed most calls were attended within 35 minutes of the allocated time. Less than 3% of calls in the previous week were over 35 minutes early/late.

Staff had assessed risks to people's health, safety and wellbeing. However, risk management plans were not always clearly presented.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received a range of training to support them to provide care that met people's needs. Staff had received regular supervision.

We found consent forms that had been signed on people's behalf when there was no evidence the person signing had legal authority to this.

People told us staff prepared food to their preferences and ensured they had drinks available.

Is the service caring?

Good

The service was caring.

Most people told us they received support from the same care staff on a regular basis. However, we also received reports that care staff the person did not know could be sent without an introduction or the person being informed of this in advance.

People told us staff respected their privacy and supported them to remain independent as far as was possible.

Whilst most people told us their care staff were kind and caring, this was not consistently the case. We received multiple reports of instances where people had requested care staff weren't sent again due to the lack of a caring approach.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The office copies of people's care plans did not always accurately reflect the care they were currently receiving.

People told us they would feel confident to raise a complaint. We saw complaints had been investigated and responded to in a timely way.

People told us their regular care staff provided person-centred care that met their needs and preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Ineffective action had been taken to address known issues in relation to the completion of medication records and the safe management of medicines.

There was a lack of robust audit and quality monitoring to help monitor and improve the quality and safety of the service. There had been a lack of effective action taken on the findings of an external auditors report.

Staff felt supported and were motivated. We received mixed reports from people using the service as to whether there was good communication with the service.

Premier Care Limited - Trafford & Manchester Homecare Branch

Detailed findings

Background to this 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.

The inspection took place on 12 and 13 September 2017 and was announced. We contacted the registered manager the day before the inspection started to let them know we were coming. This was to help us plan the inspection effectively. The service is a domiciliary care agency, and we asked the registered manager to arrange for us to visit and phone people using the service in advance.

The inspection team consisted of three adult social care inspectors and two experts-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.

The provider completed a Provider Information Return (PIR) in February 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we reviewed information we held about the service, including: Previous inspection reports, the provider's PIR and notifications the provider had sent us about safeguarding and other significant events. We looked at any feedback we had received about the service since our last inspection. This included four concerns/complaints we had received by phone to our contact centre or via a 'share your experience' form submitted on the Care Quality Commission (CQC) website.

We contacted Healthwatch in Manchester and Trafford and the contracts and quality monitoring teams in Manchester and Trafford local authorities for feedback prior to the inspection. We received feedback from Manchester and Trafford local authorities which we used to help plan our inspection. No significant concerns were raised by either local authority and we have reflected the information we received from them in the main body of this report where relevant.

During the inspection, two adult social care inspectors visited the service's office in Stretford, Trafford. On the second day of the inspection, one of the inspectors visited four people using the service in their own homes. The third adult social care inspector carried out additional phone calls to members of care staff. The two experts-by-experience carried out phone calls during the inspection and spoke with an additional 20 people receiving care and support from the service and 12 people's relatives. We spoke with the registered manager, eight members of care staff, four care co-ordinators/supervisors, the training officer and the recruitment officer. We also spoke briefly with the area manager, one of the directors and the provider's head of governance.

We reviewed records relating to the care people were receiving. This included 12 people's care files and care plans, five people's medication administration records (MARs) and daily records of care. We also looked at documents relating to the running of a domiciliary care service, including: Records of complaints, policies and procedures, eight staff personnel files, audits and surveys and records of training and staff supervision.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2016 we identified concerns in relation to people receiving their care calls on time and we found one instance where there had been a missed call for a person who had recently been discharged from hospital. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although we found some ongoing issues in relation to missed calls and the timeliness of calls, the provider had made sufficient improvements to meet the requirements of this regulation.

Both Trafford and Manchester local authorities told us they had received complaints in relation to late calls and consistency of care staff. In the past year the provider had notified CQC and the local authority safeguarding team of missed or significantly late care calls affecting six people. The registered manager and care co-ordinators told us they would always look at whether they had sufficient numbers of staff available in a certain area before agreeing to take on a new package of care.

Some people's care calls can be 'time critical' due to them having to receive medicines at set times or having to receive support with meals due to health conditions such as diabetes for example. We saw the provider monitored staff punctuality for attending such calls, and a report they provided to us showed that there had been one call classed as time critical that had been more than 30 minutes late in the week prior to our inspection. The registered manager told us this had been due to traffic, and that the call was only classed as time critical due to the family's preference.

The majority of people we spoke with told us they had not recently experienced any missed calls or calls that were significantly delayed. The provider told us they aimed to attend all non-time critical calls within a 30 minute window either side of the allocated time, which was to allow flexibility in case of heavy traffic or the person on the previous call requiring additional support. Most people told us they received a phone call from the provider if staff were running late, although this was not consistent. Comments we received included, "I did have a couple of missed calls, but this was going back some months now and certainly for the last two of three months, a carer has turned up every time, albeit very late on quite a number of occasions," "Staff are normally on time. They are infrequently late. They ring normally to let me know if they are late, which is rare," and "It varies a little bit, generally they come on time. They don't always let you know if they are going to be late. The carers [staff] will turn up, they don't let you down."

The provider used electronic call monitoring to check whether staff attended calls and arrived on time. This involved staff using their mobile phones to scan a code when they entered and left people's properties. We saw the correct clocking in and out procedure was followed on 85% of calls the week prior to our inspection. The registered manager told us any calls that were not logged using the correct procedure had to be verified by staff at the office before staff attendance was confirmed. The registered manager told us the system automatically alerted staff in the office if any calls were overdue by 30 minutes or more. They provided us with a report that showed in the week prior to our inspection, less than 3% of all 5,377 calls undertaken that week were more than 35 minutes early or late. The majority of calls that were outside the 30 minute tolerance had been carried out within 40 minutes of the allocated call time. The registered manager told us

there had been no recent missed calls, and they ran a report from their electronic call monitoring system that confirmed this, and showed there had been no missed calls since mid-June 2017.

The provider had a procedure in place to follow if staff were not able to gain access to a person's home when they arrived for a call. During the inspection we found staff were following this procedure, and heard the care co-ordinators raising a concern with the local authority where they had not been able to access a person's home. However, shortly after the inspection we received a notification from the provider that informed us of an incident where staff had not gained access to a person's home and had not followed the correct procedure to report and escalate this concern appropriately. The provider referred this issue to the local authority safeguarding team, and we are currently gathering further information about the incident.

People we spoke with told us that staff gave them the support they needed to take their medicines. Staff were aware of the correct procedures in relation to administering medicines safely and the actions to take if there were any concerns in relation to people's medicines. However, not all staff had followed good practice in the administration of medicines consistently. In the past year the provider had notified CQC of 11 medication errors by staff that they had referred to the local authority safeguarding team. This included instances of alleged overdose or missed medicines administration. In at least one instance there had been a misunderstanding between staff and others involved in a person's care as to who was responsible for administering their medicines. Whilst we saw this information was reflected in people's care plans, it was not always up to date. For example, we saw one person's care plan and the electronic information available to staff indicated that Premier Care staff should administer their medicines. We asked one of the care co-ordinators if this was still the case, as there were no medication administration records (MARs) in their file since April 2017. The care co-ordinator told us they thought district nurses now administered this person's medicines and they told us this person had a small consistent care team. We confirmed this by checking the rota. However, the lack of up to date information in relation to who was responsible for administering medicines would increase the risk of a medicines error occurring.

We found records of medicines administration were poor and difficult to understand. We found multiple gaps on MARs where medicines had not been signed for and there was no information as to why this was the case. Instructions on the MARs were also not always clear. For example we saw some medicines had been crossed through, although there was no explanation why this was done, such as because the medicine had been discontinued or a short course of medicine completed. Other medicines did not state the dosage of the medicines or how much of a medicine should be administered. For example, one MAR just stated 'citalopram' and 'am' had been circled. These shortfalls would increase the risk that staff would not understand what medicines needed to be administered and when.

The registered manager showed us they had started to address the issue of staff not signing MARs when they administered medicines and showed us an example of a member of staff who had received a written warning in relation to gaps identified on the MAR sheet when they had been responsible for supporting a person with medicines. However, we were concerned that it was presumed that the error related to documentation. We couldn't see that any check had been carried out to determine if this person had actually received their medicines as prescribed. The provider had notified us of an incident in August 2017 where a person had gone without their medicines for several days as they had run out and staff hadn't reported this appropriately. We found the staff involved had not been suspended from administering medicines and they had not had further medicines training or competency assessments to help ensure they weren't putting other people at risk through unsafe practices. The registered manager told us they hadn't done this yet due to the safeguarding investigation being ongoing. However, it would be reasonable to take such actions, which should not interfere with ongoing investigations.

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.

People told us they felt safe when being supported by Premier Care staff. They told us members of care staff carried identification, wore a uniform and remembered to lock their door when leaving.
One relative told us, "[Family member] is 100% safe with staff," and another said, "I trust them [care staff]. They are excellent."

Staff had received safeguarding training and they told us safeguarding was also discussed in staff meetings and supervisions. Staff were aware how to identify potential safeguarding concerns and told us they would report these to the registered manager or a care co-ordinator, although not all staff were clear on the reporting procedures. Some staff were able to provide examples of concerns they had raised with the registered manager and they told us these had been acted on promptly.

The provider had identified and reported safeguarding concerns to the local authority safeguarding team and CQC as required. We saw the registered manager kept a log of safeguarding incidents and carried out investigations when this was requested by the safeguarding team. One safeguarding incident involved an alleged assault by a staff member on a person who was using the service. The police had found evidence to support the allegation and the member of care staff was required to make a formal apology. Premier Care had taken appropriate action such as suspending the staff member when the allegations became known to them. In a second more recent case of alleged assault, the provider informed us they had reported the incident to safeguarding and the police. They told us the actions agreed with the safeguarding team had been to stop any further calls this staff member had with the person making the allegation and to carry out spot checks of their practice. We saw evidence the spot checks had taken place as agreed and no concerns in relation to their practice had been identified. The registered manager told us they had received no further contact about the incident from the police or safeguarding since their initial referral in June 2017.

Staff told us they felt comfortable reporting any concerns to their manager. They were aware of other staff within Premier Care they could approach if they didn't feel able to go to their line manager. However, the provider's policy did not support robust procedures in relation to whistleblowing. We found the policy directed staff to go to their manager with any concerns. It did not indicate who staff may be able to approach either internally or externally if they had concerns they did not feel able to raise within the normal management chain. The provider told us they would review this policy.

The provider had assessed risks to people's health and wellbeing. These included environmental risk assessments that considered whether people's home environment was safe, that smoke alarms were fitted and that there were no trip hazards. Staff produced action plans if any issues had been identified. Separate risk assessments were in place in relation to any moving and handling support needs people had.

We saw staff had considered whether people were at risk of skin breakdown, choking or were vulnerable if accessing the community. However, we found risk management plans were not always in place when risks in these areas had been identified. For example, one person was assessed as being vulnerable if they left their home and risks were identified in relation to wandering, anxiety, memory loss and self-harm. There was no guidance in this person's care plans or risk management plans for staff as to any actions they needed to take to help control and reduce risks in these areas. A second person was identified as being at risk of pressure sores, and there were no details in the care plans as to how staff should reduce risks in these instances. In a third case, we saw the person had been identified as not being at risk of pressure sores when there was evidence that they would be at increased risk of developing a pressure sore due to reduced mobility and incontinence.

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.

We saw the provider kept a record of accidents and incidents. We saw all recent accident records related to accidents staff had had. The provider had not notified CQC of any serious injuries being sustained by anyone using the service in the past three years. The provider confirmed this was correct and that no person using the service had recently sustained any serious injuries or had any accidents whilst staff were providing support. Staff we spoke with were aware of procedures to follow in the event that someone had an accident or required medical assistance. One person's care plan contained information about when servicing for their hoist was next due, which had passed. The registered manager confirmed staff did not routinely update this record. They told us staff were aware they had to check equipment before each use, including checking the date of the last service on the servicing labels.

The provider had a robust recruitment process in place to help ensure staff were of suitable character to work with vulnerable people. We saw staff had completed an application for employment that outlined their previous experience and qualifications, and all staff had a minimum of two references on file. Members of staff had Disclosure and Barring Service (DBS) checks in place prior to them starting work with Premier Care. DBS checks show whether the applicant has any criminal convictions and help employers make safer, informed decisions about who to recruit.

Staff were aware of good practice procedures in relation to minimising the risk of the spread of infection, such as through regular handwashing. People told us staff always carried personal protective equipment (PPE) such as gloves and aprons with them. One person told us, "They [the staff] wash their hands and they do wear gloves. I have seen them the odd time put a plastic pinny [apron] on."

Requires Improvement

Is the service effective?

Our findings

Most people we spoke with felt care staff were competent and had the skills required to provide them with effective care. However, we also received comments from people that the standard of care varied widely between individual members of care staff. Comments included, "I was surprised by how good they [care staff] are. I have a turner [piece of equipment] and the staff know how to use it", "The regular ones [care staff] are competent but new ones not. We have a couple of care staff who we have asked to be replaced as they didn't have the natural skills. They [Premier Care] acted straight away and replaced them" and "Unfortunately not all the care staff are of the same standard and I sometimes despair when I see a certain member of staff coming through the door as I know everything won't be done to the standard that other staff provide."

Staff said they received regular training and told us a member of the management team would carry out spot checks of their competence. They told us the training was of good quality and that they would receive additional training and support if they didn't feel competent. Training records showed staff had received ongoing training in a range of topics relevant to their roles. This included training in moving and handling, infection control, safeguarding, first aid and accredited training in end of life care. In addition to this training we saw staff were in the process of completing accredited vocational qualifications such as health and social care diplomas.

There was an induction process in place for new members of staff that incorporated the standards laid out in the care certificate. The registered manager told us all new staff were recruited subject to a 13 week probation period and that all staff completed at least two days shadowing with experienced staff. The care certificate is a set of minimum standards that should be covered for new care workers. Following the standards helps ensure any new care staff are competent to provide safe and effective care.

Staff told us they received regular supervision and appraisal, which records confirmed. Supervision allowed staff the opportunity to discuss any training needs with their line manager, along with any issues or concerns they wished to raise. The registered manager also used supervisions to provide feedback to staff on their performance, and to offer support where any development needs were identified. This process helped to ensure staff remained accountable and supported in their job roles.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff told us they would check people's care files to see if they had consented to their planned care. They also said they would ask for people's consent before providing any support and would respect people's

wishes. People we spoke with confirmed this. One person told us, "None of the care staff force me to do anything that I'm not ready for" and a relative said, "Yes absolutely [staff ask for consent]. Some days [family member] doesn't want a shower and they respect this." This shows staff were aware of the need to obtain consent where possible and to work in the least restrictive way possible.

The registered manager told us no-one supported by the service was currently subject to any restrictive practices. They were aware that the use of restrictive practices amounting to a deprivation of liberty had to be authorised by the Court of Protection, and they told us they would approach people's social workers to progress such applications.

We saw some people's care files contained mental capacity assessments. However, it was not always clear that these assessments were specific to any particular decision. It is important that capacity assessments are decision specific as it may be possible for staff to support people to make some, if not all decisions that affect their care. The registered manager told us there was a current review of this documentation taking place, which should address this issue and ensure capacity assessments were decision specific.

We saw some people's care files contained forms for them to sign to indicate they consented to their care plans. However, we saw two consent forms had been signed by a relative and there was no evidence these family member's had legal authority to consent on their behalf, such as a lasting power of attorney for care and welfare.

We recommend the provider reviews and implements guidance in relation to the implementation of the Mental Capacity Act (2005).

People's care records outlined what support they needed to prepare food and drinks if this was part of the support provided by Premier Care. People we spoke with confirmed staff helped them prepare food to their preferences and we observed that staff had left people with drinks within easy reach. One person told us, "The care staff don't leave without giving me a cup of tea. I can't fault them" and another person said, "If I want a sandwich, they [the staff] make if for you. They give me a choice and a cup of tea, which is nice." One relative told us, "The carer sits with [family member] when they are eating and they encourage them to eat properly." Records showed staff worked with other health and social care professionals and made referrals when required to services such as speech and language therapists (SALTs), occupational therapists, district nurses and social workers.

Good

Is the service caring?

Our findings

People told us their preferences were listened to in relation to the gender of care staff, and also the care staff they preferred to carry out their calls. One person said, "I like male care staff and I told them this when I started with them. They only ever send me lads now."

One member of care staff told us they had supported the same person for 11 years. People we spoke with also told us small teams of consistent care staff usually provided their support. This had helped staff and people using the service get to know each other and develop positive relationships. Comments included, "I always have the same four care staff", "The two or three regular carers I see know me well" and "The same two care staff come during the week and it's a different staff member at the weekend. It is beneficial to [family member] to have the same care staff and Premier Care have kept to this." The registered manager showed us they were able to run a report from their electronic call monitoring system that helped them check whether people were receiving care from a consistent team of staff. The provider set a target in relation to the maximum number of staff that supported each person that was based on the number of calls the individual received each week. The report showed that in the week prior to our inspection, the provider had not met their targets for 13 (4%) of the 340 people they supported.

Whilst people had generally received care from a small team of staff, we also received comments that staff the person had not met before would sometimes be assigned to calls without people first being told to expect them. One person told us, "I have one or two regular care staff that I see quite often, but other than that it can be lots of different staff and it does make it difficult for me because I then have to endlessly explain to people how I like things to be done." The provider told us they did try to inform people if staff the person did not know were being assigned to their call, but that this was not always possible when changes had to be made at short notice.

People told us that staff supporting them were kind, caring and understanding. Comments included, "They [the staff] are lovely, don't know what I'd do without them", "My care staff are excellent, they can't do enough for me" and "They are comical and you are put at ease right away". However, one person also commented that there were large variations between different members of care staff. They told us, "In my experience there are those care staff who are really good and know exactly how to look after me and treat me as an individual. And then there are a few who I really wonder why they're doing this work at all because they don't show any sympathy or understanding for either me or the condition I find myself in."

People told us staff respected their privacy and dignity and left their homes clean and tidy. During our visits to people's homes we saw care staff interacted positively and respectfully. People told us staff were mindful to shut curtains before providing any support with personal care. One relative told us their family member's sight had deteriorated and that their family member was a 'very proud' person. They told us staff helped maintain their dignity by being observant and intervening to ensure any clothing their family member put on was clean. Another relative told us, "Staff always talk to and not down to [family member]. The staff always want to know how [family member] is. They like to have banter with them and I'm sometimes amazed how much they can bring out a spark in her."

People told us they felt comfortable expressing their views to staff and they had been provided with information and explanations about the care they would receive. People said staff supported and encouraged them to retain as much independence as was possible. For example, people told us that staff allowed them to complete tasks at their own pace and encouraged them to do what they could for themselves. One person told us, "I feel the staff are rushed, but they don't rush me" and a second person said "They [staff] encourage me to be independent. When I tell them to, they leave me and I do things for myself."

Staff had received training in dignity and diversity. The registered manager told us they supported people from diverse backgrounds and that their workforce was equally diverse. They felt this helped them to provide care and support that could be tailored to people's needs. The registered manager told us no-one using the service currently had an advocate. However, they were aware of local services that were able to advocate for people to help ensure their voice was heard if this this was required.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2016 we found not all complaints had been dealt with effectively. We found this to be a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

People told us they would feel confident raising a complaint if they felt this was required. They told us they would do this by calling the office and raising their concern with a manager. We saw some people had 'spot inspection' forms in their care plans. These included a prompt for the staff member carrying out the review to check that the person knew how to make a complaint if they wished to do so.

Most people we spoke with who told us they had raised complaints said they had been satisfied with how their complaints had been handled and resolved. One person told us they had raised repeated complaints in relation to the quality of some of the care staff and the timings of their calls but felt little action had been taken to address these concerns. Other people we spoke with who had raised similar concerns told us the provider had taken effective actions to resolve their concerns such as changing the staff who visited them for example. The provider had a complaints policy in place. Records of complaints showed formal complaints had been investigated and responded to appropriately and promptly.

People told us they had been visited by a member of staff who had come to discuss their needs and preferences in relation to their care when they first started using the service. One person told us, "When I started with the agency a nice man called [staff name] came and sat down with us and talked about what help I needed and how I would like the care delivered. He went away and then sent us a care plan which had everything in it about myself and what help I needed. This is in my folder where the care staff sign the records each time they visit." We saw that some people's care plans had not been completed until between two to 11 days after their service had started. Staff told us information on people's support needs was always in place when they visited and the registered manager told us key information would have been in place in those people's home files from social worker's assessments, which would also be recorded on the electronic care system that was accessible to staff via their work mobile phones.

Care files were well organised and contained information on the tasks staff were expected to carry out, contact details, and information on people's health and social care support needs. This included information on people's preferences, and any communication, religious or spiritual support needs. Some, but not all care plans contained information on people's social histories. This may have been as it had not been possible to obtain this information from people using the service or their family members.

We saw staff had recorded recent care reviews or spot checks of people's care. The registered manager told us these checks would include a review of the care plans. However, this was not always clear from the documentation, and we received both positive and negative reports from people when we asked if they had been involved in reviews of their care. Care plans were not always kept up to date and were not always clear about people's current support needs. For example, one person's care plan and advice from a speech and

language therapist (SALT) indicated they received normal consistency fluids. However, the care co-ordinator told us this person now received custard consistency fluids. We saw this information was accurately reflected on the electronic care system, but had not been updated in the office copy of the care plan. We saw in another person's daily records that they were being assisted by district nurses in relation to the dressing of wounds. However, there was no reference to any wounds or the involvement of district nurses in this person's care plan.

People told us that their regular care staff offered them choices and provided care and support as they wanted. One person said. "They do things the way I like them" and another person told us, "When my care staff arrives in the morning they will always ask me if I'm ready to have my shower. If I'm not, they will usually make me a cup of tea and sort my breakfast out for me, by which time I'm usually ready to make a start." However, people who had raised concerns about staff they did not know visiting on a regular basis told us they had to re-iterate their preferences to these staff, or found they did not receive person-centred care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in April 2016 we found a high number of late calls and inconsistency in staff providing support to individuals. The provider's quality assurance and monitoring processes had failed to adequately address these concerns. We found this to be a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made sufficient improvements, and there was an ongoing breach of this regulation.

We were told daily records including logs and medication administration completed by care staff were returned to the office every other month. However, we found two people's records had not been returned for a period of two months and one person's records had not been returned for three months. Records of medicines administration (MARs) we reviewed were incomplete and unclear. The registered manager told us they had introduced checks of MARs and that they were targeting staff who were particularly poor at completing these records. The registered manager showed us an example of a MAR that had been checked and found to have gaps where the staff member had not recorded any administration. However, we found that none of the MARs we reviewed had been checked, and there was no other regular general audit of medicines to help monitor whether the service was following safe procedures in relation to medicines management. Where issues had been identified in relation to the completion of MARs, we were also not satisfied that sufficient consideration had been given as to the cause of any errors. Staff completed daily records of care in booklets, which contained a section at the back of the booklet to evidence the logs had been reviewed and any issues followed up. However, we found this section was blank on all the daily logs we reviewed.

The registered manager was able to produce reports via the electronic care monitoring system that provided them with information about aspects of care such as consistency of care staff and timeliness of calls. They told us they regularly went through this information with the area manager who visited the branch weekly. However, given the large size of the branch we found the scope of monitoring and audits in place was limited. For example, there was no overview or analysis of trends in relation to complaints, accidents or safeguarding incidents. There was also no robust system in place for checking and recording equipment such as hoists had been maintained and were safe to use. The registered manager told us the electronic call management system was in the process of being upgraded and should allow additional reports to be produced in the near future.

The provider informed us they commissioned a twice yearly external review of the service, which was used to help them monitor performance and compliance with the regulations. We saw the last external audit had taken place in March 2017, which was to follow-up the findings of the previous audit in December 2016. Whilst the provider had addressed some of the issues this report raised, we found there had been a lack of effective action taken in relation to other concerns. The audit showed that the provider had first been made aware of concerns around the safe management of medicines, record keeping, the adequacy of the whistleblowing policy and lack of audits (including MARs and daily logs) in December 2016. These issues were ongoing at the follow-up audit carried out in March 2017 and had still not been resolved by the time of this inspection in September 2017. This shows the provider was not using the audit as an effective tool to

drive improvements to the quality and safety of the service, and the provider was not acting on the advice of the person who had conducted the audit.

These issues relating to record keeping and the lack of effective monitoring and improvement of the quality and safety of the service were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the provider had sought feedback from people using the service through a recent telephone survey, as well as a paper based survey. The majority of responses provided positive feedback about the service. We could see that the registered manager had followed up and addressed any concerns that people had raised as a result of the feedback from the telephone survey. People we spoke with confirmed they had been asked for their views about the service. However, they also told us they had never received any feedback on the findings of such surveys or what changes were being made as a result of the findings of the surveys. When asked if they had completed a survey, one person told us, "Yes, every year. No feedback." Staff also sought feedback from people using the service through a system of 'spot checks' carried out by the co-ordinators and supervisors, during which people's care records were checked and they were asked if they were happy with the service they were receiving. However, not everyone felt the service was responsive to and acted upon requests they made in relation to call times and consistency of staff. The registered manager told us there could sometimes be delays in the local authorities who commissioned people's services agreeing to changes in call times, but that the service had recently started putting changes in place prior to these being agreed with the commissioners so as to meet people's needs and preferences in a more timely way.

The service had a registered manager who had been in post for six years. The registered manager was supported by an area manager, and the provider also employed a quality assurance manager. We spoke with a director of the company who told us that as far as possible, administrative functions such as the payroll were managed by the provider to enable individual branches of the company to focus on the delivery of care. The registered manager oversaw a team of care co-ordinators and supervisors who were responsible for tasks including carrying out assessments, reviews and organising rotas. There was also a recruitment officer employed by the service.
Staff we spoke with felt the service was organised and well run. They told us the registered manager and other members of the management team were approachable and supportive. One staff member told us, "The manager is really approachable and sorts things out." A second staff member said, "I don't have any problems with the management. They arrange my rota well and can always be contacted." Staff had access to an 'on-call' for support and advice outside the normal office hours. They told us the manager who was on-call always returned their calls.

Whilst most people using the service and their relatives felt Premier Care was well run, we received mixed feedback from them when asking if they were able to easily get in contact with staff at the office. Some people told us they had no problems getting through to staff in the office and told us their queries were usually resolved quickly. However, other people commented that calls often went through to the answerphone and were not always returned when a message had been left. One person told us, "Probably only one out of every four of my calls to the office will actually get answered first time, and getting through is no guarantee that they'll be able to answer my query. They usually just say that the person I need to speak to is unavailable and they will call back later, which they usually forget to do." However, a relative we spoke with said, "Phoning the office is no problem. I have spoken to them [office based staff] and there are no issues with the on-call either." The registered manager told us the care co-ordinators also ran drop-in 'surgeries' to provide people with the opportunity to meet face to face, and to help improve communications with people using the service.

Staff were motivated and told us they enjoyed their job roles. They told us they felt valued by people using the service and Premier Care for the work they did. One staff member we spoke with told us they were proud to make people using the service feel 'happy' and said, "At the end of every call I know I've done my utmost to make people happy. People ask for me to come back which is a compliment." When asked if they felt other members of care staff had the same caring values, they told us, "Yes, I do think all staff are caring and respectful... I know staff will do what they are supposed to." A second member of staff told us, "Premier Care is the best company I have worked for. They are very flexible and supportive. The [registered] manager is lovely and patient."

The service had submitted notifications in relation to allegations of abuse as required. There had been no notifications submitted in the past year about other notifiable events such as serious injuries, police incidents and deaths, and we found no evidence any such events had occurred and not been appropriately reported.

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 The provider was not managing medicines safely. The provider was not adequately managing risks to people's health, safety and wellbeing. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to adequately monitor and improve the quality and safety of the service. Regulation 17(1)