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

Summary of findings

Overall summary

This inspection took place over three days on 26 and 27 April and 9 May 2016. We made phone calls to people using the service on 28 April 2016. The first day was unannounced, which meant the service did not know we were coming. The second and third days were by arrangement.

The previous inspection took place in April 2013, when no concerns were identified.

Premier Care Homecare is a domiciliary care service which means it provides care and support, including personal care, to people living in their own homes. At the time of this inspection the service was providing support to around 350 people in Manchester and Trafford. People received between one and four calls a day. There were approximately 140 staff. They were organised and supported by a team of office staff based in Stretford.

There was a registered manager who had been in post since 2012. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found that people generally were happy with their regular care workers. There were very few missed calls reported. When there was a missed call it was investigated in order to prevent a recurrence.

Premier Care Homecare were using modern technology to ensure care workers had accurate rotas and to reduce the number of missed or late calls. This enabled staff to log in or out and alerted the office if a care worker had not arrived.

However, there was still a high rate of late calls, some of which had been reported to the CQC. Many of the 24 people who were using the service and ten relatives we spoke with said they had received late calls, especially when their regular care workers were not on duty. Other people told us that carers were unreliable, coming at different times. There had also been a missed call for someone who had just come out of hospital. We found there was a breach of the regulation relating to meeting people's needs.

Staff were trained to recognise any signs of abuse and report them as needed. The registered manager conducted disciplinary proceedings to ensure a safe service was maintained.

Safe recruitment practices helped to ensure only suitable staff were employed. Staff were trained in the administration of medicines and kept records. We have made a recommendation relating to improving the handling of medication.

There was a system of training and shadowing for new staff. There was a specific form used for supervision at the end of training to ensure that staff were ready to deliver care independently. Existing staff received

regular refresher training from an in-house trainer. Staff could also receive more detailed training in other subjects. The provider attached high importance to the delivery of training.

Staff received regular supervisions and spot checks, which were unannounced.

The Mental Capacity Act 2005 was applied when appropriate and the service had conducted its own mental capacity assessments.

Staff could help with food preparation. They would co-operate with medical professionals.

The majority of people we spoke with thought the care workers were caring and helpful. Some people said they enjoyed their company and regarded them as friends.

There was also some negative feedback, but in some cases there were alternative explanations. When people told us about isolated examples of poor care, the registered manager said she would take immediate action.

The service stored records securely.

The care planning and risk assessment system used by Premier Care Homecare was thorough and person-centred. Information was obtained about people's life history in order to enable staff to engage with people on a personal level.

One problem we encountered was that the care planning document was completed by hand and was not always easily legible.

Care plans were reviewed at regular intervals in the home of the person receiving the service.
Annual surveys were done but the results were kept at head office.

We saw that complaints were not always handled effectively.

Staff were aware of the vision of the service. The office staff worked efficiently and the structure of the organisation meant the registered manager could delegate responsibility.

We saw reports from Manchester City Council had been responded to positively.

People using the service could often not recall completing a survey, but said they could speak to the office if there was a problem.

The registered manager reported events to the CQC as required under the regulations.
Staff meetings were held in the different areas where staff worked

Audits were completed by head office which identified whether all required documents were present in files but did not assess the quality of the contents. This meant there was insufficient monitoring of the service. This was a breach of a regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In relation to the breaches of regulations you can see what action we have required the provider to take at the end of the main report.

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.

People were generally satisfied that the service they received was safe.
Missed calls were investigated and lessons were learnt from them. There was a relatively high rate of late calls which some people and their relatives found unsettling.

Staff were trained in safeguarding and the registered manager reported incidents appropriately.
Medicines were recorded but not always in the correct way.

The service had safe recruitment processes. Disciplinary procedures were used when needed.

Is the service effective?

Good

The service was effective.

New staff received training and shadowed other members of staff until they were ready to work on their own. Existing staff received regular ongoing training.

There were regular spot checks and supervisions to support staff and identify any additional training needs. Staff were trained to observe people's health needs and call for help when needed.

The service was working within the principles of the Mental Capacity Act 2005 and was carrying out mental capacity assessments when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of people thought their care workers were polite and caring. However, there was a significant minority who recalled instances where they thought the care provided had fallen short.

People were encouraged to remain as independent as they

could.

Staff were assigned to support the same people on their rotas. The service respected the confidentiality of people's personal information.

Is the service responsive?

Requires Improvement

The service was responsive. Care planning was thorough and information about people's personal history was gathered to help make the care person-centred.

Reviews of care plans took place at regular intervals.

Complaints were not all handled effectively. We were made aware of some people who were dissatisfied with the response to their complaint. The registered manager ensured that these people received a further response after we raised it at our inspection.

Is the service well-led?

Requires Improvement

The service was not always well led.

The staff shared the vision of the service. There was an effective structure to the organisation.
Staff meetings were held, and staff told us they could raise ideas at supervision.

The registered manager responded positively to suggestions and criticisms. Audits were conducted by staff from head office but it was not clear how detailed they were. There was insufficient monitoring of the quality of the service.

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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.

This inspection took place in late April and early May 2016. On 26 and 27 April 2016 the lead inspector visited the offices of Premier Care Limited - Trafford & Manchester Homecare Branch ("Premier Care Homecare"). The first visit to the office was unannounced. On 28 April another inspector and an expert by experience made phone calls to people using the service. Then on 9 May 2016 the lead inspector returned to the office to conclude the inspection.

An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert by experience had personal experience of supporting older people.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted the commissioning officers in Manchester City Council and Trafford Council and asked them for feedback about the service. The registered manager provided copies of the latest two monitoring reports

by the contract officer of Manchester City Council.

In the office we spoke with the registered manager, two care co-ordinators, one of the directors of Premier Care Limited, and two care staff. We looked at records relating to the service, including eight care records, four staff files, medication administration records (MARs), policies and procedures and quality assurance records. We reviewed records about training, and complaints, and we looked at policies on safeguarding, whistleblowing, and complaints.

We spoke by telephone with 24 people who were using the service and ten relatives.

Requires Improvement

Is the service safe?

Our findings

We spoke with 24 people who were using the service and ten relatives and asked them whether they felt safe. People told us they trusted the staff and were happy with the arrangements for them to gain access to their homes. One person said, "They are nice and polite, I feel safe with them." One person said, "I have a key safe so they can get in and they do that alright." People also told us that they felt safe if they needed to be moved in or out of bed, using a hoist. There was one person whose view was a little different: "The majority of the time yes; more now than what I did. Something happened and I didn't feel safe; I took it further and that person no longer comes here so we are pleased." They did not go into further details about what had happened, but told us they now felt safe when the care workers came.

One concern expressed by people was that the arrival times of care workers were inconsistent. . One person said, "They come at different times. I never know when they are coming; they are supposed to come at a set time. Sometimes they come at 8 or 11. Lunchtime is 12 – 12.30; sometimes they don't come till 1.30pm. Sometimes they come at 8.45 pm for bed; they should come at 8pm." This was a common complaint among the people we spoke with. Another person, and their spouse, told us, "Two days a week we have a different carer, who struggles to get here on time. Normally at lunchtime they are late." They added that they had never had a missed call (i.e. where the care worker fails to turn up). However, another person said, "They come three days a week. Mondays and Wednesdays are okay but on Fridays they can be three hours late or don't turn up at all. When I ring up they say 'oh we'll get someone there as soon as we can' but it's not good enough. It's such a worry when they don't turn up."

Other people by contrast told us that their care workers always arrived punctually. One person said, "I have regular carers in the week and another girl at weekends; they are on time." Most of the people we asked stated that their care workers were mainly punctual, but there were more problems when their regular care worker was off. One relative said, "The girls we get now though are regular, so it's okay but the weekends can be poor. In the week they are on time but at the weekends we are all over the place." Another relative had completed an annual survey and written, "Regular staff are consistently on time, but other staff can be up to an hour late yet office staff do not think it pertinent or courteous to contact us." Someone else said, "[I] just don't know when they are coming, that's the crux of the matter."

A few people also told us they found it unsettling when unfamiliar staff arrived. One person said they had a regular care worker from Sunday to Thursday, but on the other days, "I don't know who is coming; I just have to put up with whoever comes." One relative said, "Why do we keep getting all these different care workers? We have had five different ones in this last week and I didn't know any of them." However, the majority of people we spoke with expressed satisfaction with the regular care workers who came and understood that they needed to have different care workers on some days, for example when their regular care worker was not on the rota or on holiday.

Nearly everyone we spoke with told us they had never experienced a missed call. People said, "No, they might be late but they always come," and "I've never had it where no one turned up – they turn up late sometimes." One relative did say, "They turn up at all times or not at all; we have had a load of missed visits.

I ring up and they say 'Okay', sort of 'so what'; I get no real response." This person mentioned two specific recent dates on which they said they had missed evening calls.

We checked the daily notes in the office and saw that the relative had recorded the two dates where they alleged missed visits. We discussed their concerns with the registered manager. She explained there was an issue with this particular case, in that the family would only admit particular care workers to the property. This had been discussed with social services and with the relative themselves. We saw the record of a spot check which stated, "There are some visits missing due to next of kin turning carers away at the door." We considered that in this instance the reported missed calls were not the sole responsibility of Premier Care Homecare.

From January 2015 until the date of the inspection we had received two reports of missed calls from the local authority. There had been a higher number of reports and complaints about late calls. These can sometimes be significant, if for example someone is on time-critical medication eg for diabetes. In one case in late 2015 a relative had contacted us about late and variable calls. We had contacted the registered manager who resolved the issue to the relative's satisfaction by agreeing new timings for the calls. In another recent case, the local authority requested the registered manager to investigate an alleged late morning call. The registered manager found that the allegation about the late morning call was 'partly substantiated', in other words was partly a valid allegation. She established that the care worker who had been allocated the call had been ill on the day in question, and another care worker had been found who arrived at 11.36am. She concluded that "Carer A did arrive late on 22.2.2016, although this was unavoidable." We discussed this with the registered manager. One care worker's sickness would not inevitably mean that their calls would be late if a system was in place to be able to find a replacement quickly.

Another relative told us, "The times of the carers have gone all to pot; they are never on time. It's way out of the original time slot we would expect them in. My sister and I are here at weekends so that's covered, but one time no one turned up till 11am. "When I complained they said it was unforeseen circumstances. Okay, but why didn't they ring me or my sister? Either of us would have come and not left [relative] in bed till 11am."

Premier Care Homecare were using technology to improve communication with care workers and reduce the incidence of late or missed calls. All care workers were provided with a mobile phone. Their rota was sent to them weekly electronically. They received it on a Friday for the week commencing the following Monday. Any changes in the rota were received directly on to the mobile phone, and staff also received a phone call to confirm when there had been a change to their rota. We saw that the phone provided details of each call, namely the address and name of the person receiving the service, its duration, and the care tasks. Time-critical calls were highlighted on the screen. It also gave the keycode for the keysafe if there was one. We asked whether this was a secure system and were told that each phone had its own login code, which meant the information held on it was secure.

Another use of the phone was to enable staff to record their entry and exit to a property by scanning a QR code in the person's care file. This enabled management to check the duration of calls. It also benefited people using the service. If a care worker had not scanned in within 30 minutes of the planned visit time, an alert was triggered and appeared on the computer system in the office. Office staff would then investigate where that particular member of staff was and, if necessary, send a replacement.

The registered manager told us that Premier Care Homecare had been operating this system for about three years and found it reliable. They said the scanning system was 90% effective in monitoring calls, although there were some people who hid their care files and sometimes the phones were not working. Staff we

spoke with were more mixed in their views. One care worker told us the phone was unreliable and kept losing its charge; it would freeze and sometimes switch itself off. They then found it necessary to sign in and out of calls manually. They would also have no access to their rota if their phone was not working, unless they had a paper copy with them. Another care worker however could not praise the phone highly enough. They said the battery charge lasted a week. They found using the mobile phone much better than the previous system.

The registered manager mentioned a recent missed call had occurred because a new care worker had not yet received a mobile phone, and was using a printed rota. Someone had been discharged from hospital and a call needed to be added to the rota. The care worker did not realise that the call had been added. The system flagged an alert and the care worker received a phone call (on their personal mobile) but said there was no need to visit as the person was in hospital. This was accepted by the office, and the call was missed. This demonstrated that the system was subject to human error, and that if the service depended on the use of mobile phones they should be given to new staff as soon as they were working independently.

The number of late calls and inconsistent timings of calls described above indicated that people were receiving a service which sometimes did not meet their needs. The example of the missed call for someone who had just come out of hospital represented a risk to the person using the service and a failure to meet their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Premier Care Homecare had a detailed 'No Access' policy which instructed care workers and office staff on the procedures to follow if staff could not gain access to a property, and the property did not have a keysafe. This included ringing the office and the person's relatives. This policy was intended to keep people safe if they were unable to answer the door when they usually did so.

We obtained a copy of the provider's safeguarding procedure which was out of date. It was dated September 2014 and required updating to reflect the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force in April 2015. We knew from referrals received from the two local authorities in the areas served by Premier Care Homecare that the registered manager reported safeguarding incidents appropriately and co-operated with investigations. She conducted her own investigations when requested to do so by the local authority, and we had seen that the investigations were thorough.

Disciplinary measures were taken against staff when needed. For example it was alleged in July 2015 that a care worker had failed to prepare food but had recorded that they had completed this task. Following an investigation the registered manager gave the care worker a "letter of concern", which was a warning about their conduct. In other instances staff received retraining or extra supervision. In one more serious case the care worker had logged manually the time they left the call as 20.30, but the family arrived at 20.10 and saw no care worker was present. A disciplinary hearing resulted in a final written warning. The family were informed. In this way the service showed that it treated such incidents seriously with a view to protecting people. The registered manager informed us that the care worker was still receiving monthly spot checks and monthly supervisions, and their performance had greatly improved.

All but two staff were up to date with training in safeguarding, and we saw that those two were booked on to training in the month following our inspection. Staff we talked with showed an understanding of safeguarding and the different forms of abuse. They knew how to report it. They said they would have no hesitation in reporting a colleague if they witnessed any form of abuse. They also told us they were instructed to phone the office in an emergency.

We looked at the recruitment records of three staff. Premier Care Homecare took steps to ensure they recruited people who were suitable to work with vulnerable adults. The application form required a full work history going back 5 years and accounting for any gaps in employment. Proof of identity was on the file. A record was kept of answers given at interview and also of an assessment test. Two references were obtained. We noticed that in the case of one recruit references had been obtained from two friends but not from a former manager who was mentioned in the application form. This created the risk that the references might not be wholly objective and the agency could not be assured that this person was fit to undertake this role.

Employers are required to check with the Disclosure and Barring Service (DBS) whether people applying to work with vulnerable adults have had any convictions or cautions. There is also a system called ISA Adult First where employers can get an interim statement before the DBS certificate is produced. Premier Care Homecare used a form headed "DBS Disclosure/ISA Adult First application", with space for a disclosure number underneath. It was not clear from the forms we saw whether the disclosure number related to the DBS or to ISA. This created potential uncertainty whether or not an employee had received a DBS certificate. We mentioned this to the registered manager who agreed that the form should be made clearer. One member of staff told us they had not been allowed to start work until their DBS certificate came through.

We looked at how medicine was managed across the service. Many people administered their own medicines, often with the help of family members. In other cases care workers were expected either to prompt or administer medicines to people. When this is done it is vital to maintain accurate records of what medicines have been given and when. This should be done using Medicine Administration Records or MAR sheets. The registered manager told us MAR sheets were handwritten because the pharmacists would not supply printed MAR sheets. The provider was planning to introduce printed MAR sheets for each person.

One care worker told us they always recorded when medicines were given on the MAR sheet in the care file. They said occasionally a MAR sheet was not available and when that happened they recorded on the daily communication sheet. We saw copies of completed MAR sheets were transferred to the office and kept on the individual's care file. People who were receiving support with their medicines had a medication risk assessment on their file which advised staff about any issues to do with their medicines. We also saw lists of the medicines that people were taking, although one of these was handwritten and illegible.

We found improvements were needed in relation to medicine management and recommend the provider access NICE guidance to ensure medicine is managed in line with best guidance protocol.

Accidents and incidents were recorded centrally in the office. We obtained a copy of the provider's whistleblowing policy which made it clear that staff were encouraged to feel confident about raising issues around safety or other issues. Staff doing so would remain anonymous, where possible, and be protected from reprisals or intimidation. We had not been contacted or made aware of any whistleblower since the previous inspection.

Personal Protective Equipment (PPE), such as gloves and aprons, was made available to staff. We received no complaints from the people we spoke with about the standards of hygiene.

Good

Is the service effective?

Our findings

We asked people whether they felt staff were well trained. One person told us, "I feel confident with staff." Another person replied by saying, "I don't know, but I have the cleanest bath and toilet in the world." A third person said, "They seem well trained, but I have nothing to compare it to."

A record of the training provided to new staff was kept on their files. We saw from individual employees' records that they had received induction training in core subjects necessary for their role. Examples of core training subjects included: person centred care, dignity in care, communication, food hygiene, health and safety, infection control, moving and handling, safeguarding, basic first aid, fluids and nutrition and management of medication. Staff confirmed that they had received this training when they started.

Induction included shadowing an existing member of staff and on the job assessment. Some of the people we spoke with confirmed that their care worker sometimes brought someone with them who was shadowing them. One member of staff who had been working about a year told us they had received a lot of practical training by working with other staff.

We saw the training matrix, a record of ongoing training, which showed when all staff had last received refresher training in core subjects. All staff except two were up to date in these subjects, and we were assured that these two staff were booked on to refresher training within the next month. Staff spoke highly of the in-house trainer who delivered training in most of the topics. We did notice that the different topics were all covered on the same day for most people attending training, which would make it quite intense.

One member of staff told us, "I love my training. We have training twice a year, in small groups, for two or three days." They said they received training over the year in health and safety, moving and handling, basic first aid, food hygiene, medication, safeguarding and the Mental Capacity Act 2005 (MCA). They gave an example of when their training had come in useful. They saw that the person they were supporting was having a stroke, because they recognised the symptoms of a stroke, and they knew how to give cardiopulmonary resuscitation and had done so.

As well as the core subjects there was a range of more advanced training which some staff had undertaken. Most of the staff had received training in dignity and equality in care, person-centred support, and catheter care. Around 15 staff had received dementia awareness training, although given the nature of the people supported by Premier Care Homecare it would be beneficial for everyone to receive this training.

We considered that the service delivered sufficient training to enable staff to perform their tasks effectively. We saw a detailed training and workforce development plan which showed that training was a priority for Premier Care Homecare.

Supervisions were arranged every three months and spot visits were arranged every six months. A spot visit was when an office supervisor or coordinator turned up unexpectedly at a visit and observed all aspects of the care worker's performance. We saw records of these spot visits on staff files.

A 'Staff Initial Supervision Form' was used for the first supervision after induction. It included sections about how the induction training and shadowing had gone, identified any further training needs, and provided a checklist for the member of staff and their line manager. This was a good way to ensure that staff were ready to undertake care visits on their own.
When a supervision was due it was added to the staff member's rota so they should remember to come into the office. They were paid for the time of the supervision

During regular supervision sessions, staff were asked to comment on their own performance, their working relationships with colleagues and individual customers, and whether they felt skilled enough and understood how they should be carrying out their duties. This would lead on to identifying any training needs staff might have.

Staff we spoke with confirmed that the supervision sessions were a useful exercise and were not used only to impart information but to enable them to raise their own issues. This meant that staff were supported to share any issues that might affect their work, and were encouraged to think about improving their practice. One care worker told us, "Supervision is useful. It is a chance to voice issues." Staff also had annual appraisals which were a chance to look back at the previous year and discuss any issues regarding the year ahead.

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 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. The registered manager and the care co-ordinators demonstrated a good knowledge of the principles of the legislation. They understood that family members, unless they have a relevant power of attorney, cannot give consent for treatment or care on behalf of someone who lacks the capacity to do so themselves. We saw that in most cases personal support plans were agreed with and signed by the person concerned.

The registered manager told us that the service usually relied on mental capacity assessments completed by the local authority, but did conduct its own assessments when necessary. We saw a mental capacity assessment form used by the provider across a range of services, which we considered was fit for purpose. The form made it clear that the assessment was for a specific decision. It also explained that if a person was assessed as lacking capacity in relation to a decision, then that decision needed to be made on the basis of the person's best interests, after a consultation. This meant that decisions affecting people using the service should be made in accordance with the MCA.

All staff received training in food hygiene as part of their induction and then as an annual refresher course. However many of the lunchtime or teatime calls were commissioned by the local authorities to be 15 or 20 minutes long, which meant there was not time for elaborate food preparation. One person said "I taught the girl how to make cheese on toast – they make a sandwich mostly." Another person said, "Microwave meals, not much time for anything else. I tell them if it's not hot enough and they have to put it back in the microwave." A third person said, "They do my meals; sometimes I put it in the oven beforehand and they can serve it up when they come. I like my food and they do it okay." For the most part people were satisfied with

the assistance they received with preparing meals.

We saw evidence in the care files that the service co-operated with medical professionals. Staff were trained to call an ambulance at once in the event of a medical emergency. One care worker gave a recent example where they had called the office because of a medical condition of the person they were supporting, and the advice from the office was to call a doctor. They stated that in an urgent emergency they would phone 999 before informing the office.

On one occasion the care workers (on a double call) had become concerned about the health condition of the person they were supporting. One of them wrote in the daily notes that they had spoken to a family member, "We told her in our opinion [person's name] should get checked out – they are extremely breathless on moving and in discomfort with their stomach." As a result of this conversation the family member called a doctor and the person was admitted to hospital. This showed that the care workers had acted appropriately to protect the health of the person using the service.

Requires Improvement

Is the service caring?

Our findings

We saw a letter from one person, "I would just like to thank you for the support I have received. My carers could not do enough for me; nothing was too much trouble for them to do." Another person told us, "The regular ladies are very good, very nice to me and kind; they look after my needs well." A third person said, "Staff are considerate and do everything they are supposed to do." The majority of people we spoke with described their care workers as polite, friendly and nice.

People told us that the care workers considered their privacy when delivering care. "My carer is very good, most polite and helps me with my privacy when I wash." And a relative said, "They look after [my relative] very well, very kind and attentive. They look after their privacy when they shower them and things like that."

People told us that the care workers involved them by asking them what they wanted doing. One person told us, "They speak to me when they come in, do the job then they ask if I want anything doing. They put cream on my legs if I want it on." Another person said, "Staff say 'Do you wish to have a wash?' – can't get any better than that." A third person told us, "I can wash and dress myself; the carers put my socks on. They don't automatically do things for me – they help me to keep my independence." This showed that care workers respected people's independence and only provided the support that they wanted.

People appreciated the company of their care workers. "I have a laugh and joke with them; they seem to enjoy it." Another person said, "I have two regular ones and one other. It's like having a friend come round to see me; it really is nice. I have a good laugh with them." One care worker told us, "I like to think that people are getting 100% care. I take care of them like I would my own family. I encourage people to do what they can. I always try to put a smile on their face."

At a care plan review the person receiving the service stated, "Happy with the service and carers. With the help of the carers I can stay in my home."

We also heard some negative feedback from a number of different people. One person said, "There are two lads who come regular and are really good; they wash their hands and then set about what they have to do, but the other one who comes walks in, doesn't say anything, fills in the book first and signs it then says, 'here is your pills' and goes." Another relative, when asked whether the service was caring, said, "Yes they are if you can call 5 -10 minutes caring when it's supposed to be 15 minutes."

One person who was otherwise positive about the service recalled an occasion where they had been made to feel uncomfortable. "Last year I was told to rush into the bathroom – the man said 'Come on, hurry up.' No person should tell you what to do." They added, "I prefer women carers; they're so gentle with me."

We discussed this feedback with the registered manager on the last day of our inspection. It was evident that there was a majority of people who were satisfied with the service and found the care workers to be caring and considerate. But there was a minority who at one time or another had found the service to be less caring than they expected.

Some people gave us the above examples of substandard care. We discussed individual cases with the registered manager and in some instances she was able to understand why the people using the service or their relatives might have been unhappy. In other cases she had been unaware that people were dissatisfied. She agreed that more frequent spot checks and monitoring, and perhaps a phone call to check that people were happy with the service, might help identify people's concerns at an early stage and enable them to be addressed.

We saw from rotas that usually the same staff were assigned to visit the same people on a regular basis. This enabled staff and people receiving the service to build up a relationship and meant that staff could gain knowledge of each person's needs and preferences. However there were some people who told us they were unhappy with the number of different carers who visited them.

In the office we found that people's care plans and personal documentation were stored securely in locked cabinets so that confidentiality was protected. One of the topics for discussion at a staff meeting held at the end of April 2016 was, "What information is acceptable to disclose and what is not." This showed that the staff were encouraged to think about the issue of confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Premier Care Homecare used a care planning document called 'Care needs and risk assessment' when planning care for each person using the service. The registered manager told us that the intention was to complete this document before the service commenced. We saw that the registered manager endorsed the care file by writing, "All required information is within the file and the customer is now able to receive services." There were occasions when a new package of care needed to be started urgently, in which case the document was completed at the first opportunity. However, a co-ordinator told us that Premier Care Homecare would often refuse to accept new packages if there was not sufficient time to plan the care.

The second page of the document contained contact details of the person using the service, key agencies and their next of kin. The next page had a section called 'Social history' and asked for information about the person's life, including their childhood, school and work history. There was also a 'Personal profile' section which included a person's likes and dislikes, social interaction, ethnicity, religion and related details. We saw on care files that these sections had been completed, although with varying amounts of detail. As one of the co-ordinators explained, it depended on how much information could be obtained from the person concerned and from family members. The purpose of these boxes was to enable care workers to gain a good understanding of the person they were supporting, and perhaps to engage them in conversation about things they were interested in.

The document went on to provide information about the person's health and any impairments, their personal care needs including continence, any safeguarding needs and food management. There was detailed information about medicines, creams and ointments and other health related issues. There were risk assessments relating to moving and handling and environmental risks, which included any risks to the care workers relating, for example, to access to the property. Towards the end was a risk management plan for the service to complete. A copy of this document was kept in the care file at the property of the person using the service as well as in the office.

We considered that this document was a thorough and sound basis for the delivery of person-centred care, and that the examples we saw in care files were completed sufficiently to enable staff to have a good understanding of the people receiving the service. This was especially relevant for new staff or for staff filling in for regular staff. Care workers we spoke with said they did read the care plan. We had one reservation because the 'Care needs and risk assessment' was filled out by hand. On one document the list of medicines was almost illegible. On another document the supervisor's handwriting was hard to decipher and gave the impression of having been written in a hurry. Staff completing care plan documents should ensure that care workers and other health professionals are able to read their writing, along with others who might need to access the care file.

The care plan was reviewed at intervals. A relative said, "A lady came from the office and checked the paperwork and asked if everything is okay." Six weeks after the care package commenced a supervisor or care co-ordinator would conduct an initial review at the person's home. A co-ordinator told us that this review always involved a visit to the person's home and was therefore not just a paper exercise. We saw on

care files that the reviews took place in this way.

We saw that a review of one file had been completed by a supervisor and the person had signed the file. There was also a 'client spot check' after six months. We saw completed checks on care files. This involved a visit to check the care file and other paperwork, and that the person was happy with the service provided. The spot check included the questions, "Are visits consistent?" and "Are regular times evidenced in the daily notes?" The supervisor would arrange to talk with family members if that was appropriate. There was then an annual review. We saw on care files that reviews had been completed according to these schedules and they represented meaningful assessments of the care being delivered.

Communication logs, which were the daily notes completed by staff on each call – were brought into the office at the end of each month, where office staff would check them. They could assess whether anyone's needs had changed based on the information in those notes. We discussed with the registered manager the need for staff who made daily visits also to observe any changes and to report them back immediately. She assured us that this happened.

Annual surveys of people using the service were conducted and were sent to the provider's head office. We did request to see data from the latest survey but did not receive it from head office. However we saw that some surveys were kept on care files.

We obtained a copy of the provider's procedure on 'Comments, suggestions and complaints'. It stated that people should be given every assistance to help them understand the complaints process. It also stipulated that complaints should be reviewed if possible by staff who were not involved in the events that gave rise to the complaint. The registered manager told us that complaints made verbally were recorded as 'concerns', and were also responded to in the same way as complaints. We could not identify 'concerns' on the record of complaints.

We found two examples where people were not satisfied with the initial response to their complaint. One relative who commented in the annual survey about the lateness of some staff added, "When I tried to raise issues with the management I feel excuses were made but my actual complaint/issues were not really dealt with or listened to." The registered manager told us that in response to this comment in the survey she had been out to discuss their concerns with the relative, and agreed a resolution.

Another relative told us, "My relative has just come out of hospital, is now on oxygen and the medicines have changed and, firstly the girls who came today had no idea that [my relative] was on oxygen or that their medication was different, but Premier Care knew, and secondly, the pm visit has been shortened to 20 minutes. How on earth can they get [my relative] on the commode, do her tea, then her medicines, and redo her oxygen in 20 minutes?" This is quite serious and I would be concerned that the provider had not conducted an assessment of need. I think the point is being overlooked.

We asked whether the relative had raised a complaint and they confirmed they had, but were not happy with the outcome. They told us, "The care co-ordinator was only interested in asking me which care worker had told me they couldn't do it in 20 minutes, and I told them I didn't need a carer to tell me that, you just can't." We raised these concerns with the registered manager who told us shortly after the inspection that a meeting was held with the family, whose concerns related primarily to the timing of calls. She said, "We have explained we are currently visiting at the commissioned times but will check rotas for availability." This demonstrated a willingness to respond promptly to complaints including those identified by our inspection.

The registered manager had told us in the PIR that 14 complaints and concerns had been received in the

previous 12 months. We reviewed the file of complaints and saw that they had been investigated and responded to in a timely fashion. One relative told us on the telephone that a complaint had not received a response, but we saw from the file that a letter had been sent at the time. Although the person might not have received the letter, it showed that their complaint had been considered.

The evidence we found indicated that not all complaints were dealt with effectively. We were not satisfied that verbal complaints were treated in the same way as written complaints. One person had complained about a potentially serious matter but their complaint was dealt with only after they raised it again with us during our inspection. This was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The vision of Premier Care Homecare was set out on their paperwork: "We look after people who need help getting through the day."

This vision statement was mirrored by what staff at different levels in the organisation told us. One care worker said to us, "I love doing what I am doing. I really take pride in my work. If I think a person needs more assistance, or if I need to mention anything about one of the other carers, I always go to the registered manager. She runs the office brilliantly. She always deals with any complaints." Another care worker said, "I'm not in it for the money, I find the job very rewarding; feeling like I'm helping other people."

The registered manager had been in post for about four years. The service had grown considerably in that time and during the previous year. Despite this, the registered manager had a good knowledge of individual people using the service and was able to respond to our requests for information. There were approximately 140 staff, who were organised into geographical areas each with their own co-ordinator. The co-ordinators were office based, and were responsible for organising the rotas, arranging cover when needed, accepting new care packages and staff supervision. In addition there were three supervisors, who were out and about more often, conducting both staff spot checks and 'client spot checks', care plan reviews and risk assessments, as well as some staff supervisions. There was also an office administrator.
Our perception was that the office staff were well organised, although located in small premises. Files that we requested were found readily, except for some information that was located in the head office. Care workers told us they felt supported by the office. One said they would not hesitate to ask the registered manager if they needed any support.

We saw the reports of the latest two monitoring visits by a contract officer of Manchester City Council, in December 2015 and April 2016. The first described some difficulties experienced by Premier Care Homecare in August 2015 when they had taken over a large number of care packages and some staff from another provider. Initially Premier Care Homecare did not have enough local staff to cover all the calls and to ensure that the same staff continued to visit the same people as before the takeover. The contract officer stated that some of the staff had decided at the last minute not to join Premier Care Homecare, but that the service was actively recruiting in that locality. By the time of our inspection the problems had been sorted out and the co-ordinator for that area told us things were working well.

The second report, from a visit on 20 April 2016, identified no serious problems. It stated that 13 people, out of 295 currently being funded by Manchester City Council, were receiving support from a higher than ideal number of different care workers each week. The ideal maximum number was defined in the report as being four care workers if each visit was by a single care worker, or eight if there were two care workers on each visit. The registered manager had responded that she would look into this, but it was potentially influenced by recent staff holidays over the Easter period. We saw that the registered manager did not adopt a defensive response to the findings but was willing to co-operate with a view to finding ways to improve the service.

We mentioned earlier that annual surveys were sent to people using the service. We saw some completed survey forms but were not able to see a summary of the results of the recent survey, which we were told was kept in head office. Many of those people we spoke to on the telephone could not recall having completed the recent survey, but some could remember having done one in the past. One person said "I can't remember a survey or questionnaire, but I have the office number if I needed it." Several people said the same. Whereas most people recalled receiving a visit to review their care plan.

The registered manager stated in the PIR that there were both formal and informal staff meetings. Several separate meetings were held with the same agenda, in order to accommodate the number of staff, and they were held in different areas to make it easier for staff to attend. The registered manager said there was usually a good attendance, which was monitored.

The staff meeting appeared in people's rotas If a member of staff missed two meetings, they were informed they were expected to attend the next one. We saw the agenda for the meetings in April 2016. It included many reminders to staff about expectations about their performance. It was not clear from the agenda that staff were encouraged to contribute their own ideas at the meetings, but one care worker told us they would prefer to do this at supervision sessions. The registered manager told us that the service used to produce a weekly newsletter, which was given to staff when they came into the office each week to collect their rota, but now that rotas were sent electronically to their mobile phones the newsletter had stopped. Given that everyone had a company mobile phone there might be an alternative way to communicate messages weekly to staff.

We asked about checks on the quality of the service. Each care file had an annual review conducted by a supervisor alongside the person receiving the service, and if appropriate with their family. MAR sheets and daily notes were brought into the office at the end of each month and checked by a supervisor. They were then kept on the person's file before being archived.

As mentioned earlier, all care workers received a spot check every six months. We saw a completed spot check form which recorded that the care worker arrived on time, was wearing the correct uniform and badge, followed correct health and safety procedures, read the support plan before providing care, attended to privacy, dignity and the wishes of the person receiving the service. There was also space on the form for any comments made by the person. This form showed that the spot check was a thorough process and could be used to identify both good and bad practice.

The registered manager told us that she did not keep a register of missed calls, which meant there was no definite record of how many there had been. We asked about other audits and the registered manager told us these were conducted by head office. We received the completed audit control document following an audit of care files in March 2016. The auditor had looked at all the care files and identified where documents, in particular the annual review form, were not present in a handful of cases. It was not clear from this audit whether the documents had been looked at from the point of view of quality. Since the audit had looked at over 300 files this appeared unlikely. This head office audit was not therefore a quality audit of the care files. There was also an audit of all the staff files, conducted in January 2016, which similarly identified whether all the documents were present but did not report on the contents of those documents.

At this inspection we found evidence of a high number of late visits and inconsistent timings, and of people receiving visits from many different carers. We also found examples of substandard care. We considered that the monitoring systems in place had failed to identify these issues, which meant there was scope for improvement. The provider's audits did not produce any practical or positive information to help improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The registered manager held a monthly branch review with directors of the provider, which she told us was useful. She did not have minutes of these meetings. The provider had a good reputation for working with local councils. One of the commissioners told us, "Premier Care participate in all partnership engagement with Trafford and are very responsive to support requirements in the borough."

The registered manager was aware of her responsibilities under the regulations to report significant events to the CQC. We had received notifications completed by her or a co-ordinator, but on occasions had to request further details. We had not always received updates to explain the outcome of an investigation or disciplinary process.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that the timings of calls met the needs of service users. Regulation 9(1)(b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not operating effectively a system for handling complaints. Regulation 16(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems to assess, monitor and improve the quality of the service. Regulation 17(1) and 17(2)(a)