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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Premier Care Limited - Trafford & Manchester Homecare Branch (known as Premier Homecare) is a domiciliary care agency providing personal care for people living in their own homes. The service was supporting 220 people at the time of our inspection.

People's experience of using this service and what we found
Risk assessments had not always been reviewed and the guidance to manage the risks was not always clear or detailed enough. Staff wore the required Personal Protective Equipment (PPE).

Premier Homecare had struggled to recruit to vacancies in their office staff. This had resulted in care plans not always being reviewed, staff spot checks / observations and supervision meetings not being completed. Staff had been safely recruited.

Quality audits were not completed for care plans, daily notes and staff files. The provider's quality team had started to support the service and had identified similar issues in October 2021.
People received their medicines as prescribed. Monthly medicines audits were completed, and any issues identified had been actioned. Improvements had been made in the management of medicines since our last inspection.

People were very positive about the support provided by the permanent Premier Homecare staff. However, they had several issues with the agency care staff used to cover calls. We were told the agency staff rushed the calls.

Care staff said they felt supported and could contact the office if they had any issues. However, they also noted that this was more difficult since the office staff numbers had reduced.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 June 2020) and there were two breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections.

Why we inspected
We carried out an announced focused inspection of this service on 30 January to the 5 February 2020. Two

breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection (September 2019) to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the lack of detailed guidance for managing risks, the risks not being reviewed as planned and the quality assurance system not being robust at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Premier Care Limited - Trafford & Manchester Homecare Branch

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by two inspectors. Three Expert by Experiences made telephone calls to people receiving support from Premier Homecare and their families. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 25 January 2022 and ended on 4 February 2022. We visited the location's office on 25 January and 3 February 2022.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used this information to plan our inspection.

During the inspection
We spoke with six members of office staff, including the registered manager, operations manager, medicines co-ordinator, care co-ordinator and care supervisor.

We reviewed a range of records, including eight people's care records and multiple medicines records. We looked at four staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including quality assurance were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Three Experts by Experience spoke with 45 people who received a service or relatives by telephone. We also spoke with 12 members of care staff by telephone. We looked at further quality assurance documents, surveys and incident reports.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Risks people may face were identified and guidance provided for support staff to manage these risks. These were planned to be reviewed annually or if any there were any changes in people's support needs. However, half of the care plans we saw had not been reviewed within this timescale.
- Clear guidance was not always in place for any specific support required. For example, one person's moving and handling assessment stated for staff to use an Etac turner (an Etac Turner is an aid to support people to stand and turn safely) for supporting the person to transfer to the living room. There was no further information about the support the person needed to be able to use the Etac turner safely. It did not state whether the person could walk with support after using the turner or required a wheelchair.
- An assessment of the environmental risks within each home was completed, for example, lighting and access to the property. However, these were not always correctly completed. For example, one person's assessment stated there were no risks associated with infection control, but staff needed to clean the commode and so were dealing with bodily fluids.
- Staff told us the information they were able to access via their work phones about people's risks and support needs was 'basic' and was not always updated as people's needs changed. One member of care staff said, "They should update the risk details on our phones; it could be different than the information in the house files." Another told us, "I can see information on my works phone but sometimes it needs more detail; there's not enough information sometimes."

The failure to robustly assess the risks relating to the health safety and welfare of people was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care staff were provided with sufficient Personal Protective Equipment (PPE) and knew the current government guidelines to follow during the COVID-19 pandemic. One person told us, "They always wear their PPE and change gloves regularly."
- Staff were encouraged to participate in weekly COVID-19 testing. If staff tested positive they were advised to isolate, and a discussion held to establish the calls they had made and if there had been any breaches in the use of PPE. People and colleagues they had worked with were contacted if needed.

Staffing and recruitment

- People were complimentary about the permanent Premier Homecare care staff. They arrived on time, stayed for the full length of the call and were flexible if they were asked to do any additional tasks. One person said, "The Premier Care staff are all very good, all very capable. I trust them with anything" and another told us, "The regular staff, it's a really good service. They always stay the allocated time and really

work with me, like a team."
● However, people were not happy with the temporary agency staff support used to cover vacancies and annual leave. We were told they rushed calls, didn't stay the full length of time and were not flexible about the tasks they were asked to complete. One person said, "Half of the agency carers don't stay very long, they are miserable, and the timings are no good." A relative said, "Some agency staff turn up and don't know anything about her and mum gets confused with this."
● We discussed this with the registered manager, who said they had not received any poor feedback or complaints about the agency staff. They said they would investigate the concerns we raised.
● Premier Homecare had struggled to recruit to the office-based co-ordinator and supervisor roles and had carried vacancies in these areas for several months. This had impacted on the services ability to review and update people's care plans, carry out quality phone calls with people, undertake spot checks and have supervision meetings or calls with staff.
● Staff were safely recruited, with all pre-employment checks completed prior to a new member of staff starting work. Staff completed induction training and shadowed experienced staff before working on their won.

Using medicines safely

At our last inspection the provider had failed to robustly monitor, record and manage the safe administration of people's medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 12(1).

● A medicines co-ordinator had been recruited since our last inspection. They checked Premier Homecare had the correct medicines information for all new clients and when people were discharged from hospital.
● People received their medicines as prescribed. Staff completed regular training in medicines administration. Medicines administration records (MARs) were fully completed. The registered manager audited the MARs each month and any issues identified had been actioned.
● Clear assessments were written to identify what support each person needed to take their medicines safely and who was responsible for providing the support, for example, Premier care staff or the person's family. Written guidance was in place for when 'as required 'medicines needed to be administered.
● A positive audit by the local authority medicines optimisation team had been completed in August 2021. The recommendations made had been implemented.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff knew how to report any incidents or accidents. The registered manager reviewed these and reported a monthly summary of all incidents, safeguarding reports and complaints.
● A new electronic incident reporting system had been introduced the week before our inspection, This would enable real time reviews by the registered manager and the provider's central quality team to ensure relevant actions had been completed to assess the incident and reduce the risk of a re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

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

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

● The service was trying to recruit one care co-ordinator and two care supervisors. A new co-ordinator was due to start work shortly after our inspection. This had resulted in care reviews, quality check phone calls to people using the service, staff spot checks and supervision meetings / calls had not been completed as planned. We were told these were done where an issue had been identified, for example if a complaint had been made.
● This also meant observations of staff using PPE or administering medicines had not been completed. Staff told us it could take time when they reported changes in people's needs to be updated in people's care plans.
● The medicines administration records were reviewed each month. However. we did not see evidence that a sample of the care plans, staff files or daily notes were checked on a regular basis. As reported in the safe domain, not all risk assessments had been reviewed and others lacked detail.
● We requested an updated report on when each care plan had last been reviewed or updated but this was not available via the electronic care planning system.
● These issues had been identified in a provider audit in October 2021. An action plan had been written to address the shortfalls, however we found similar issues during our inspection.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Most of the care staff were positive about working for Premier Homecare and felt supported, whilst also noting the support they were able to get from the office had reduced since there were fewer care

supervisors. A member of care staff said, "If I've any concerns I can always speak with someone at the office" and another told us, "I can speak with [registered manager] and the staff in the office are helpful when I call them."

● People told us they were able to contact the office if they had a concern or complaint. They said this was usually addressed. One person said, "I would call the office, they are very helpful. I have phoned them, and I was satisfied with response."

● The provider carried out regular surveys. The latest survey from September 2021 was positive, with 70% of respondents saying they were supported by regular staff and 82% said they were treated with dignity and respect. The registered manager had contacted people who had responded they were not happy with their support to establish the reasons and to agree how the support could be improved.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager, co-ordinators and supervisors were clear about their role. However, they had been impacted by the long-term vacancies in carrying out the full remit of their roles.

● The providers central recruitment and quality departments had recently started to support the service.

● The registered manager was experienced in his role and notified the CQC and safeguarding teams of any accidents and incidents as appropriate.

Working in partnership with others

● The registered manager met monthly with the lead social worker for the areas they operated in. They discussed any issues that had been raised by the social work teams and the registered manager could alert the social workers to any changes in people's needs that needed to be re-assessed.

● The registered manager was also part of a group organised by the local authority, looking at the care provision (both residential care and care in the community) that will be required in the future.

● The local authority quality monitoring team were positive about Premier Homecare. They said they were meeting the standards for carrying out calls on time and the length of each call was within their contractual agreement.

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 Risks relating to the health safety and welfare of people were not robustly assessed and reviewed.

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