Premier Care Limited

# Premier Care Limited - Trafford & Manchester Mental Health Branch

## Inspection report

8 Premier Street
Old Trafford
Manchester
Greater Manchester
M16 9ND

Tel: 01612262270
Website: www.prem-care.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 over three days in June 2016. We gave 48 hours' notice before the first visit on 16 June, so that the service would have time to let people know that we might contact them by telephone. On 17June we visited two people using the service in their homes, and also telephoned eight people to ask them about the service. On 21 June we concluded the inspection.

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

Premier Care Limited - Trafford & Manchester Mental Health Branch provides care and support for people living in their own homes in and around Old Trafford, in Manchester. At the date of this inspection 27 people were being supported. Most people were living in shared houses. Most of the people using the service had experienced mental illness in the past, and the service monitored their mental health. There were also three people with learning disabilities living in one house.

There was a registered manager in post who had been registered in April 2015. 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.

People we spoke with told us they felt safe. For the most part their care workers arrived reliably on time. The care workers contacted them if they were going to be late. The office monitored calls and could respond if the care worker had not turned up for any reason. The service also carried out a daily check that houses were secure.

Staff were trained in safeguarding although not all staff were up to date with refresher training. The safeguarding policy was not up to date. We found that some events which should have been reported to us as incidents of abuse had not been reported. This was a breach of the regulation relating to safeguarding people from abuse.

The service ordered medicines and delivered them to people's homes. Some people administered their own medicines, other people were prompted. Staff kept records which were checked each week to ensure that medicines were taken as prescribed.

Staff were involved in helping and encouraging people to keep their houses clean.

Proper processes were followed to ensure that only suitable people were employed. New staff received induction training and shadowed existing staff. Ongoing training was provided through annual training days but some staff were overdue refresher training. There had not been role-specific training in recognising a deterioration in mental health, although we were told there was an intention to reintroduce it. This

deficiency was a breach of the regulation relating to providing suitable training for staff.

There was regular supervision of staff, who told us they felt supported in their work. Staff assisted people using the service with shopping and cooking, according to their level of need for support. The service helped people with accessing healthcare. The service had not carried out any mental capacity assessments on people using the service.

People told us they felt well looked after, and that they were helped to have a good quality of life. People were encouraged and enabled to live as independent lives, as they could. However we did not find evidence that people were actively supported to move on to a more independent living arrangement.

Some people received support to access the community. We also saw that staff would sometimes go beyond what they were contracted to do, to support people. There was one person who complained about the support they were receiving.

Care records were kept confidentially in the office but not in people's homes.

Care plans were created on the provider's standard template which could be made more specific to the needs of people using this service. Some of the details we saw in people's plans were incorrect. There was some evidence that files were reviewed, but it was inconsistent.

Annual surveys of people's views took place, but on the last occasion only half the people had received a survey to complete. People told us the registered manager came to see them to ask their views.

The complaints policy was out of date. The complaints log recorded only two complaints in 18 months.

The failure to report notifiable incidents was a breach of the relevant regulation. There was also a breach of the regulation requiring providers to update the organisation's statement of purpose, when the service took on people with learning disabilities.

Some audits were done, for example the medication audit, but there had not been any audits of care plans. This was a breach of the regulation relating to monitoring the quality of the service.

The service had a clear purpose of maintaining people's mental health while assisting them with daily activities. Staff said they found the job challenging but worthwhile. Some of the processes and paperwork needed to be updated.

We found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and two regulations of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of the 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 told us the care workers were usually on time. The office kept track of when care workers arrived to make calls, which helped to ensure people did not miss a call. The service made security checks to ensure people were safe.

Staff were trained to recognise cases of potential abuse. However, several incidents had not been reported appropriately as safeguarding concerns.

The service ensured that medication was available, and kept adequate records. Staff encouraged people to keep their properties clean. Recruitment procedures assessed the suitability of staff to work with the people using the service.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

New staff received induction training. Nearly a third of staff were overdue refresher training, which took place annually. A course geared to the needs of people using the service had not taken place for two years.

People received help with shopping and food preparation, according to their needs. Some people told us they had been helped to develop cooking skills.

Staff at the service were working in accordance with the principles of the Mental capacity Act and everybody using the service was assumed to have capacity to make decisions.

### Is the service caring?

**Good**

The service was caring.

Most people told us that they were happy with the level of care provided and the friendliness of staff. There was one exception, but staff did not know about this person's concerns.

Staff went beyond what they were contracted to do to look after people's mental health. The service did not actively encourage people to move on.

Confidential information in care files was stored in people's houses.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans included personal information about each person but some details were wrong.

There were some unnecessary sections in the care plans and not enough detail about people's mental health.

Surveys of people using the service took place but they were not given to everybody.

The complaints policy needed updating. There had been few complaints recorded, which had been dealt with appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The service had not been submitting notifications as required to the CQC, and had not updated its statement of purpose.

Some audits were carried out regularly but there was no evidence of audits of care plans.

The service had a vision statement and was carrying out its purpose of supporting people who had experienced mental health difficulties. Staff felt well supported. Some procedures and paperwork needed to be updated.

# Premier Care Limited - Trafford & Manchester Mental Health 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.

This inspection took place on 16,17 & 21 June 2016. We gave the service 48 hours' notice of our inspection so that they could make arrangements for our telephone calls. The inspection team consisted of one inspector, and an expert by experience who made telephone calls to people using the service. 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 experience in supporting older people and people with a history of mental health issues.

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 notifications. A notification is information about important events which the service is required to send us by law.

We visited two people using the service in their homes, and spoke with another eight people by telephone. In the office we spoke with the registered manager, a senior care worker, three care staff and two office staff.

In the office we looked at records relating to the service, including three care records, three staff recruitment files, daily record notes, medication administration records (MARs), maintenance records, complaints,

records of accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

We looked at how well Premier Care protected people who used the service from abuse. We requested the service's safeguarding policy which we received by email following the inspection visit. This policy was not specific to Premier Care and the service users of this branch, but a generic multi-agency policy created by Manchester City Council in June 2010. It was therefore out of date, and did not contain contact details for Trafford Council, where the service was located. Significantly it did not contain any advice or information for staff about what signs of abuse to look out for among the particular service users they were supporting. It was therefore not fit for purpose.

Staff told us they received annual refresher training in safeguarding and this was confirmed from the training record, although there were five staff (out of 17) who had gone a few months further than one year since they had last had the training. The training and workforce development plan, dated May 2016, stated that this and other topics should be repeated annually, and we were told training was being arranged for those five staff. Staff said that they looked out for signs of abuse and reported it to the registered manager or a senior care worker. One said, "Yes, I know what signs of abuse to look out for and will always tell the manager." The service had a whistleblowing policy which set out clearly that staff would be protected if they made allegations against a colleague. There had not been any whistleblowing allegations since the previous inspection.

Incidents and messages were recorded in 'client contact logs' which were completed by office staff and given to the registered manager each day. We were concerned that some of the incidents recorded in these logs had not been identified as safeguarding incidents and reported to the relevant authorities. The most serious example was when a person who used the service had gone to another house one evening and assaulted one of the people living in the house. This had resulted in a serious injury requiring hospital treatment. The registered manager told us this had been reported to the local safeguarding authority, and Trafford Council have subsequently confirmed that they received the referral. However, it was not reported to the Care Quality Commission (CQC) as it should have been.

There were other examples which had not been reported as safeguarding incidents either to the local authority or to the CQC. These included an allegation by one person against another, and occasions when the police had been called to deal with incidents. From the brief descriptions given of these events it was clear that they ought to have been identified as safeguarding incidents and reported both to the local authority and the CQC.

The absence of an appropriate safeguarding policy, and the failure to identify and report safeguarding incidents, meant that not all necessary steps were being taken to keep people safe and protect them from abuse. This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people using the service whether they felt safe. All the people we spoke with answered this question positively. One person said, "I feel safe in my house; I have my own key." Another person said "I feel

very safe." A third person told us, "Yes I do feel safe because they keep an eye on me." This person added that they had been with Premier Care for a number of years in different houses, and in one of them they had had a difficult relationship with one of the other people in the house, and asked to move out as they felt unsafe there. The service had found a different house for them where they felt much happier.

One person told us they felt safe because they had someone available to contact at any time; "I feel nervous at night but I always have someone to talk to 24 hours on the phone with any worries." The registered manager confirmed that the office was manned constantly, and people using the service were told they could phone the office at any time. This was a way to protect people who might be anxious or if they needed help because their mental health was becoming unstable.

We asked people whether their care workers were reliable. One person told us that staff usually turned up on time, "They are mostly on time;" adding, "They ring if they are going to be late." Another person said, "They are always on time and have never missed me out." This would help people to feel reassured. Someone else recalled that on Christmas Day the care worker's car had broken down, but Premier Care had managed to find another care worker to come and make their lunch. They said, "They never let us down." However, one of the people we spoke with reported that the care workers did not always arrive: "Sometimes they don't come, the last time was about two weeks ago…" We asked what they did when that happened, and they replied, "I ring the office." We asked the registered manager about this who said that if they were informed that the care worker had not arrived, the office would send another one or a member of office staff, so that the person would receive a visit even if it was late.

If a care worker found that the person was not at home when they arrived, they were instructed to inform the office immediately. The office would check if they knew where the person was and if not would take appropriate action which could mean contacting the police. This procedure was set out in the service's "No access policy". This meant that steps were taken to protect people if they were missing.

Premier Care used a monitoring system in the office to check that staff had turned up for their visits. Staff each had a mobile phone which scanned a bar code in each person's care file. They were required to scan in and out so the office could keep a record of the length of visits. If staff were more than 15 minutes late scanning in, an alert would flag up on the office computer and office staff could then check with the care worker where they were. The system was designed to prevent visits being missed, because staff could arrange for someone else, possibly from the office, to visit if the assigned care worker had not turned up. We watched the system in action and saw that it did not always function accurately; for example an alert flagged up after the call had ended. However, the office staff were able to phone the care worker and were assured that the call had taken place.

Staff also received their rota on their phones and any changes were updated on the phone. They told us they always received a phone call if there was a change on the rota, to notify them and to check it was convenient. This minimised the risk of staff not being aware of what was on their rota. Staff also told us that sometimes their phones stopped working and there was a delay before they got a new one. When this happened they used the phone in the person's home to let the office know where they were.

Some people told us their visits did not always last long enough. One person said, "When I don't have the carers coming in I find it very stressful. If someone's ill, a replacement comes in but stays only five minutes. This happens rarely." Someone else said, "They're supposed to stay with me for half an hour but they are only in for a minute to check I've taken my medication." This person added that the staff spent more time with their co-tenant. We noted, however, that the co-tenant had been absent from the property for several months and that therefore this could not be the person's recent experience.

The service was contracted to provide a certain number of visits to each person each day. This meant that people were not under constant supervision, and they were free to leave their homes when they wanted. To this extent they were responsible for their own safety, both when they were home and when they were out and about. However, these were vulnerable adults and Premier Care showed that they went beyond what they were contracted to do in order to keep people safe. For example, they carried out a daily safety check on each property, normally in the evenings, to check that the occupants were safe and the property was secure. This would reduce but not eliminate the risk of burglary. In fact a burglary had taken place the night before we telephoned people using the service. The person involved said, "I'm sorry I haven't got time to talk today, I was burgled last night. Premier Care helped me get the police and my social worker and they are here now. They are a brilliant company."

We asked about how people were supported to take their medicines. Premier Care ordered people's medication from the pharmacy and distributed it weekly to the individual houses, where it was kept in cabinets with a combination lock. The code for the cabinet was printed on staff rotas and available on their mobile phones, which had an individual PIN, so the system was secure.

In some cases staff prompted people using the service to take their medicines, in other words they got the medicines out and reminded people to take them. Other people self-medicated, which meant they took their medicines independently and informed staff when they had done so. One person told us that they took their own medicines but the care staff checked what they had taken. They said, "I take my own medicine but they check. I feel like I am in control of my care." Another person said, "They check that I've taken my medication and write it in the book." In all cases staff signed the medication administration record (MAR sheet) to record that the medicine had been taken. They used a code on the sheet to indicate when the person had self-medicated. We looked at MAR sheets in one person's house and at recently completed MAR sheets on people's files in the office and saw that they had been completed fully with no gaps. In a staff meeting in May 2016 staff had been reminded of the importance of signing MAR sheets and some staff acknowledged that they sometimes forgot to sign MAR sheets when leaving a property. From the MAR sheets we saw, this reminder had taken effect and they were now being completed fully. Staff said they would immediately report to the office if someone refused or did not take their medicines.

We were satisfied that the service had reliable systems for ordering, storing and recording medicines.

One of the houses we visited was cluttered with the occupier's belongings and the kitchen was in need of a good clean. Because people were living in their own rented homes they were encouraged to keep them clean themselves, but staff would take action when houses became too untidy or dirty. We saw records of a meeting in a house where a senior care worker stated that standards of cleanliness needed to improve and they would organise a deep clean. On another occasion the registered manager stated at a meeting of senior staff that one house was "in a disgraceful state" and requested the person living there and the staff should focus on tidying and cleaning the house. We were told this had been done. This showed that cleanliness of people's homes was regarded as a priority, which would reduce the risks of infection.

We saw there were enough staff available to fill the weekly rotas without any staff working excess hours. When staff were ill or on leave it was usually possible to replace their hours with current staff, or with office staff if necessary. However, one member of staff stated that it was sometimes difficult to provide cover during busy holiday periods. Use of agency staff was kept to a minimum. This meant that people would normally see someone from the service even if their regular care worker was unavailable.

We checked the files of three recently recruited members of staff to verify that the necessary checks had been done to ensure that only suitable staff were employed. We saw that the application form requested a

full employment history and asked for an explanation for any gaps in employment. Two references were obtained, and proof of identity. In two cases the applicants declared on the application form that they had criminal convictions, which were also disclosed on the certificate from the Disclosure and Barring Service (DBS). We asked what had been done about this information. The registered manager showed us the risk assessment which had been completed in each case, which was kept securely in the office. The job applicants had disclosed the details of the offences, which were minor and in the distant past, and the risk assessment was that their history did not prevent them from being employed in the role. These risk assessments were approved by the director of the provider. This showed there was a correct procedure for assessing the suitability of prospective employees.

The people who used the service had individual tenancies with the landlords who owned the houses. Therefore the landlords were responsible for the maintenance and upkeep of the houses. We saw that Premier Care kept copies of gas safety and electrical installation certificates. This meant that the service kept an oversight of people's safety.

Requires Improvement

# Is the service effective?

## Our findings

We asked people using the service about how well trained they thought the staff were. One person said, "Premier Care are professionals and look after my interests. The staff are excellent." Other people also spoke favourably of the staff's skills and involvement.

Recently recruited staff told us they had received a week's induction training which included shadowing existing staff. The topics covered within induction were: basic life support including first aid, food hygiene, health and safety, infection control, medication training, moving and handling and safeguarding. The same topics were renewed at annual intervals for existing staff. For each person they were covered in the same day at the provider's head office. We asked staff whether they felt such intensive training allowed them to cover the topics fully in one day and they told us they thought the training was useful and they enjoyed it.

Five staff out of 17 on the training record were overdue refresher training, although the longest that anyone was overdue was less than three months, and we were told this training was being arranged.

Some additional training topics were available to staff. Eight staff had been trained in mental health awareness, and six in effective communication and dignity in care. These topics were also taken on the same day as each other, often alongside the refresher training, and some staff had completed as many as ten topics on the same day. This indicated that the learning on each topic could not have been in depth. Staff told us that in between the training days they did not undertake any training either by e-learning or any other method.

The registered manager told us she was hoping to re-introduce a training course in 'Mental health first aid'. This was intended to train staff to recognise the first signs when someone's mental health was becoming unstable, to enable preventive action to be taken. This was a vital course for staff, given the needs and history of the people using the service. We asked whether a course like this had been instituted earlier. One member of staff mentioned that there had been an internal trainer within Premier Care who had delivered a course along these lines, but they had left the company two years earlier. There was no explanation as to why this essential course had not been delivered for two years to staff, many of whom had joined in that time.

There were therefore shortfalls in the training provided to staff. Nearly a third of staff were overdue refresher training. There was no training offered in between the annual training days. A course in recognising signs of mental distress had been discontinued, despite being essential for working with the people using this service. Together these shortcomings represented a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received supervision every two months from one of the senior care workers, or sometimes from the registered manager. The supervision often included unannounced spot checks on staff where the senior care worker would observe a visit to a person using the service. There was then a discussion between the care worker and the senior care worker. Staff told us the supervision meeting was a useful exercise where

they could express themselves. This meant that staff were supported to discuss issues arising in their work and any concerns they might have about people using the service. Staff also recalled having annual appraisals although one member of staff said they had not had one every year. We saw that staff regularly came into the office, where they could meet and support each other and office staff would provide practical help. This meant that staff did not feel isolated in their work.

Many of the tasks scheduled on staff rotas related to helping people with shopping and meal preparation. People needed varying amounts of help with the preparation of food. One care worker told us that they provided support to three people living in the same house. Two of them had a care package which included cooking for them. The care worker told us the third person also had difficulties cooking a basic meal. They would use the time available to cook a meal for all three of them, even though they had different supplies of food and wanted different meals.

On one person's care plan it was stated they should be encouraged to throw away out of date food. This showed that staff were involved in promoting the avoidance of food that was unsafe for consumption. People using the service told us that staff helped them with shopping and buying fresh ingredients.

One person said, "They used to do my meals but now I do my own, they helped me." Another person said, "Usually I cook ready meals, but sometimes they help me with cooking. I can get help with shopping and they help me choose things so I can eat healthy food." People told us, and staff confirmed that the level of support provided with cooking depended on people's needs and could change as their needs changed.

People were registered with local GPs and dentists. Staff and people using the service told us staff would often accompany people to the doctor's or other appointments. Each person's care file contained a health action plan, including information on diet and healthy eating, eyesight, dental health, and the person's annual health check. This meant that the service was involved in maintaining people's general health.

We asked the registered manager about the use of the Mental Capacity Act 2005 (MCA). The 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 MCA 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.

One of those principles is that care and treatment should only be given with the consent of the person receiving the service (or after a best interests decision if they are unable to consent). The people we spoke with all said they were treated respectfully, and none complained that anything had been done against their will. When a senior care worker introduced us to two people in their houses, they asked politely if they were happy to speak with us. The staff we spoke with all talked respectfully about the people they were supporting and said they would consult them about the care they were providing and any changes.

All the people using the service were living in their own houses in the community. As there is a presumption that people have capacity to make their own decisions, the registered manager explained that no mental capacity assessments had been undertaken with people using the service. She stated that if a person began acting in an unusual way, for example by refusing their medication or refusing food, then she would complete a mental capacity assessment to determine whether they had the capacity to make that decision. She added this had not yet happened, and no-one receiving the service had been assessed under the MCA. This was in accordance with the principles of the MCA.

Good

# Is the service caring?

## Our findings

People using the service told us, on the whole, they thought the care workers looked after them well. One person said, "I'm very well looked after, it's a good service." Another comment was, "I have no concerns, I'm very happy with staff." One person had stated in their annual care plan review, "I am very happy with the service and the staff are very friendly and happy."

Another person said, "My carers help me not to neglect myself. The carers make it easier for me to have a good quality of life. I have developed skills to look after myself." Another person said, "Staff are helpful; they help me to be independent." This showed that staff were mindful to promote people's independence, where possible. Someone else said, "I've more freedom now than other places I've been."

One person was the exception. They were less satisfied with the care they received. They said, "I feel safe but I'm not well cared for. In my folder they are supposed to take me shopping and to the doctors and lots of other things but they don't do any of them." They added, "I have the same carer but I don't really get on with her. She doesn't do any cleaning or washing up." We checked this person's care file and on their recovery and support plan they had stated, "I am really happy with my life. I don't have any worries and I have nice people around me." This plan was undated, but was written some time before our inspection. On the final day of our inspection we asked the registered manager and senior staff whether they could account for the change in attitude of the person using the service, but they were not aware of any reasons for it. They had not received any complaints from this person about the care that was being delivered. Their care plan did not specify that tasks such as washing up would be undertaken. But we knew from talking to some staff that they would help clear up after a meal, dependent on the person's ability to do so for themselves. We agreed with the registered manager's suggestion that senior staff should visit to allow the person to express their concerns directly.

A member of staff told us they treated people using the service like they would treat anyone else, and they had good relationships with them. We saw several interactions between staff and people as we visited their homes, and we saw that staff treated people with respect and kindness. Another member of staff told us that over several years they had got to know people very well, and tried to ensure that all their needs were met. They commented that one person did not go out of the house very often, and while it was not part of the care package to take them out, except for shopping, they tried to encourage the person to go out on their own.

We learnt that two of the people using the service were temporarily in hospital. Staff were visiting these people daily, even though it was not part of the service's contract with the local authority to do so. One person they were bringing back to the service on visits with a view to easing the transition back to their home. This showed that staff at the service would go beyond what it was contracted to do in order to meet people's needs. We also saw that when someone had been in hospital there was a carefully staged discharge, involving visits and then overnight stays, to ensure that the transition back to the service was successful.

One person stated to us, "I just want to be a normal person with a normal life but it is very difficult with my mental health issues." Staff told us they saw it as an achievement that people's mental health remained stable. If people were becoming unwell, or showing signs of instability, staff would spend more time with them in an attempt to avert a deterioration in their mental health.

The registered manager and other staff referred to the people they were supporting as "independent". To varying degrees people did live independently, receiving one or more visits a day from Premier Care staff but otherwise occupying themselves. People received help with managing their finances. To this extent Premier Care was encouraging their independence. We asked what help people received to move on from this service, as some people had been with the service for many years. Where people had left in recent months their tenancies had been ended as a result of their behaviour, rather than because they were moving to somewhere more independent.

We were told that only one person might be suitable to move on into a warden-controlled flat or similar arrangement. We spoke with this person and although they expressed a desire to become more independent, no practical work had been done with them to start the process. The registered manager pointed out to us that arranging such a transition would be the responsibility of the person's care co-ordinator. However, the service could play its part in moving away from a maintenance model to encouraging people's ambitions to live more independently. The service did not currently support anyone by providing a formal advocate, although they did help with filling in forms for benefit reviews, and attending such reviews or meetings with the people they were supporting.

People told us that staff respected their privacy. Personal documents were kept securely in locked filing cabinets in the office. Each person had a file with a copy of their own care plan in their home, which needed to be available readily for staff to scan with their phones on each visit. This meant the personal information in their files was not secure from the other people sharing their houses or any visitors. We were told that care files were usually kept in the kitchen. When we visited, the care files were out on the sofas in people's living rooms.

Requires Improvement

# Is the service responsive?

## Our findings

One person said they were involved in their care planning and it was all in their folder. "I have a folder with all the information I need about my care. They discuss changes with me and are always flexible to my needs." Another person said, "I discuss my care regularly with staff."

Care plans were created using the provider's standard document entitled 'Care needs and risk assessment'. The document included a section on social history, which included information about each person's childhood, working history and family life. There was also a section called 'personal profile', intended to include information about the person's likes and dislikes, and their desired outcomes and expectations. If these sections were completed fully they would enable staff to gain detailed knowledge of the person using the service, and they would be better able to meet their individual needs. The document could therefore be used to facilitate person-centred care.

However, we observed that some files did not contain a great deal of personal information. When they did, some details were wrong. For example one person was recorded under the heading 'religion' as belonging to the Church of England, but in fact they told us they were Roman Catholic. This could potentially be an important difference. Also, more than one doctor was named as their GP. This might cause confusion if the doctor needed to be contacted urgently. We brought these errors to the attention of the senior care worker who rectified them immediately.

We noticed that many parts of the standard document did not apply to people using this service. There were, for example, sections on personal care, moving and handling and continence management which were not relevant, as Premier Care Limited Mental Health Branch did not provide these aspects of care. There was no section relating to people's mental health history and current presentation, which would have been especially relevant to people using the service. There was scope for the provider to develop a tailor-made care needs and risk assessment document which would better meet the specific needs of people using this service.

People also had a 'Personalised recovery and support plan'. Some people had written their own plans, other people had signed the plan. One plan said, "I was involved in writing it and I understand what's in it." These plans did include some information about each person's mental health needs, although the amount of information varied.

One file contained a monthly activities chart although we did not see this on other files. Staff told us they regularly took people shopping but there was not much time for other activities. The service was commissioned to provide mainly short visits to check or assist with medication, cooking and cleaning. There were also a few longer visits scheduled described on staff rotas as 'community support', which could involve activities depending on the person's preference.

There was evidence of reviews on some files but these were sporadic. One file contained a review which included comments by the person using the service. There was no date on it, so it was difficult to know when

the next review was due. There were also spot checks, which recorded the views of people using the service. These were supposed to be done annually, but on one file the most recent one dated from October 2014 (20 months earlier).

There were annual surveys of people using the service. This was a series of questions with boxes to tick. We saw that the form itself was a photocopy and was not easy to use as some of the lines were missing. The completed survey forms were sent to the provider's head office, which meant that the registered manager and staff in this branch did not see people's comments directly. We were shown a summary of the results of the 2015 survey which showed that only half the people (13 out of 26) had received a survey, and of those only seven people had replied. The registered manager could not explain why only half the people had been included in the survey. In the summary the answers to questions were given, which showed high levels of satisfaction with the service.

We asked to see the policy on complaints which was dated 2010 and required updating. The complaint log went back to 2011 but contained only two complaints since the end of 2014. Staff told us there was an open door policy and people would come into the office to raise issues, which avoided them becoming formal complaints. One person told us, "The manager comes to see me every so often or rings me on the phone, I have no complaints." We saw that the two complaints had been dealt with effectively; in one the provider had become involved and held a meeting with the complainant and written a detailed letter after the meeting.

Requires Improvement

# Is the service well-led?

## Our findings

Providers and registered managers are required by the regulations to report certain types of events to the Care Quality Commission (CQC). We found some safeguarding incidents had not been reported to the CQC. There were further examples of abuse or alleged abuse, and incidents reported to the police, which had not been reported to us. We had not received any notifications of any kind since November 2014. We asked the reasons for this. We were told, and we knew from our records, that the former deputy manager, who left around that time, had been responsible for submitting notifications. It was clear that nobody had taken on that responsibility, and that notifiable events were not being reported. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We will address this failure to notify us outside of this inspection process.

The service was supporting three people with learning disabilities in one house. This house had originally been under another branch of Premier Care and had transferred to a different provider in June 2015, and then come back to this branch of Premier Care in December 2015. We asked whether staff were properly trained to support the needs of people with learning disabilities which could be quite different from those of the other people using the service. We were reassured that there were dedicated staff and a team leader who had stayed with the people throughout the various changes of provider, who knew the people well. We noted, however, that there had not been an update to the Statement of Purpose to reflect the service now providing a new category of support. This was a breach of Regulation 12(2) of the Care Quality Commission (Registration) Regulations 2009.

We asked how the registered manager and the provider kept track of the quality of the service. We saw that senior care staff made spot checks on staff every three months. They joined staff on a call, unannounced, and recorded how the visit went. The outcome of the visit was discussed at supervision with the member of staff, which was usually held on the same day. The spot check record was kept on each staff member's file, but there was no further analysis of the spot checks to identify any common themes, to share learning and improve the quality of the service delivered to people.

When we asked about care plan audits we were told they were not done by the registered manager or by anyone from the service itself, but by the provider. A named person from head office was expected to visit to audit care files, but this had not been done recently and the registered manager could not recall the last time it had been done. No records of the audits were kept in the office, and the registered manager could not state that any audits had been done in at least eighteen months. Therefore the office staff were not aware of any lessons learned. This meant there was no local oversight of the quality of the care plans, and those issues we identified in relation to records at our inspection had not been identified and addressed by the provider. This was a breach of Regulation 17(1) and 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication audits were carried out once a week. The MAR sheets were collected from people's homes, and a senior carer or the registered manager checked that they had been signed correctly. They also collected the

trays and packaging and checked that the right amount of medicines had been used to match with what was stated on the MAR sheets. These checks gave assurance that medicines were being either administered or taken by people themselves as prescribed.

The registered manager had been registered for 15 months at the date of this inspection, but had worked at the service for longer. She was also the registered manager of another service which was run from the same office, and divided her time and attention between the two services. There was an ill-defined overlap between some aspects of the two services. For example, staff told us that they sometimes were asked to work for the other service. Also, some files contained information about clients of both services. For instance the client contact logs contained records of incidents involving people using each of the two services. The registered manager and other staff were immediately able to identify which service each person belonged to, but there was the possibility of confusion and it was not easy to identify trends or risks relating only to people using this service.

The provider's vision statement was, "We look after people who need help getting through the day." This summarised the nature of the support provided. Staff told us that their main purpose was to maintain people's stability and to identify any changes in their mental health, while helping people with basic tasks such as cooking and cleaning. We have already mentioned that more tailored training for staff in recognising signs of deteriorating mental health would be of benefit. Two people using the service were in hospital at the time of our inspection but we attributed that to their chronic conditions rather than any failure on the part of the service to look after their needs. If there was a crisis, mental health professionals became involved. The registered manager told us she could also call on the directors of the provider for assistance.

Staff told us they felt the registered manager and the senior care workers were supportive. One described their work as "challenging but rewarding". They added they had not had any cause to complain while working for the service, but on the contrary had felt supported at a difficult time.

We saw that the registered manager had made some changes recently. For example client contact logs had changed. These were the logs which recorded all incidents, large or small. Until two months prior to the inspection these had been produced once a month, providing a summary of all the events listed by each person using the service. Now they were produced daily, enabling the registered manager and office staff to see immediately all the events that had occurred. The drawback to this new method was that it was more difficult to track a particular person, to see whether there had been an increase in concerns. However, the registered manager explained that because of the small size of the service they were aware whenever this happened and would respond accordingly.

Some paperwork needed to be updated. For example each care file contained a key user authorisation which included a sentence which did not make sense. We raised this with the registered manager who stated they would ask the provider to change the wording. It was indicative of a lack of initiative to update policies and paperwork or to question the way in which things had always been done.

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 Registration Regulations 2009 (Schedule 3) Statement of purpose<br><br>The provider had not updated the statement of purpose following a change in the categories of service users.<br>Regulation 12(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Notifiable events had not been reported to the CQC<br>Regulation 18(1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider was not operating systems and processes effectively to prevent abuse of service users<br>Regulation 13(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider was not operating effective systems to assess and monitor the quality of the service.<br>Regulation 17(1) and 17(2)(b) |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not fully trained to meet the needs of service users<br>Regulation 18(2)(a) |