Primecare Support Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Prime Care Support Limited is a domiciliary care agency providing personal care to older people some of whom may live with dementia.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection 100 people were receiving the regulated activity of personal care.

People's experience of using this service and what we found
People told us the level of care they received varied. This was due to visits to people not being carried out, cut short or at times earlier or later than agreed. This meant people received personal care, food and drink or medicines late or at times not agreed. Where people had care needs that required a visit at a specific time, this did not always happen.

People and relatives told us there were not enough staff to provide timely care. The provider told us they were facing recruitment challenges which had recently impacted on staffing.

Safeguarding systems and processes were not effectively operated. People were not protected from the risks of financial harm or abuse by the provider. Staff were aware of how to identify when people were at risk and reported concerns appropriately. The manager and the provider failed to take appropriate action, and when concerns were substantiated did not ensure lessons were learned to mitigate future risks. Where referrals were required to be made to the local authority these were not always carried out.

People told us that regular staff knew how to support their health and wellbeing. However, risk assessments and care plans to guide staff were not in place for everyone. Staff had not received specific training to prepare them for supporting people in areas such as skin integrity, dementia and diabetes.

The registered manager had not risk assessed how staff could mitigate the risks of contracting or spreading COVID-19 to vulnerable people.

The registered manager and provider had not established systems and processes resulting in the issues found at this inspection. We found systems were not effectively operated to identify and implement improvements. The provider had not implemented lessons learned from another of their services which had also been rated inadequate due to similar concerns.

People and relatives told us the service was not well managed. They told us they were not communicated with when things went wrong and that their visits were poorly planned. They told us they had raised issues but no improvements were made.

The manager and the provider took some immediate actions following our first day of inspection to keep people safe. For example, they recognised the impact late and missed calls were having on people and put in place a temporary suspension of new referrals.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People told us staff followed infection prevention procedures when providing personal care and wore their personal protective equipment [PPE]. Staff had received training in relation to COVID-19 and how to safely wear and dispose of their PPE.

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

Rating at last inspection
The last rating for this service was good (Published 03 July 2019).

Why we inspected
We received concerns in relation to people receiving unsafe care due to missed and late visits, medicines management and poor leadership. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

Enforcement
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 to keep people safe and to hold providers to account where it is necessary for us to do so.

We have found breaches of regulations in relation to insufficient staff, lack of training and keeping people safe from harm, also in relation to management of the service. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Prime Care Support Limited on our website at www.cqc.org.uk.

Follow up
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 return to visit as per our re-inspection programme. If we receive any concerning

information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Prime Care Support Limited

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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
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 the registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. Inspection activity started on 25 June 2021 and ended on 06 August 2021. We visited the office location on 05 August 2021. We spoke with people and their relatives on 28 June 2021 and on 15 and 16 July 2021 as we received further concerning information. We had a meeting with the provider and manager on 21 July 2021 to discuss emerging risks and gave feedback on 06 August 2021 about the inspection and to discuss what immediate actions they had taken to ensure the service was safe.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and seven relatives about their experience of the care provided. We spoke with four members of care staff. We further spoke with the registered manager and the nominated individual who was also the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included people's care records along with a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not kept safe from abuse. This was because appropriate actions had not consistently been taken when allegations were reported. Staff were aware of how to identify safeguarding concerns, however we found occasions where they reported their concern, but further actions were not completed.
- We found examples over the previous six months were incidents had been reported to the office, but referrals were not made to the local authority. For example, with one person who required support from district nurses, but who refused on occasions to visit and dress the wounds.
- Further examples were found where people had not received their medicine as prescribed. For example, medicines for the management of diabetes for one person and controlling seizures for a second person.
- People were not protected from the risks of financial harm or abuse by the provider. As management did not ensure staff logged out of the call, this meant the true time spent providing care was not recorded. When invoices were generated, both for publicly funded and private payers this meant people were charged for care they had not received.
- The registered manager did not review practise or learn lessons when the outcome of safeguarding meetings was substantiated. For example, in May 2021 two medicines error were reported to the local authority. The registered manager was asked to carry out a review of their medicines management to learn lessons and minimise the risk of recurrence. When we discussed this with the provider and registered manager neither was able to demonstrate to us where this had been completed. Further medicines errors were found to continue in June and July 2021.

Systems and process to keep people safe from harm were not followed and when harm had occurred lessons were not learned to reduce the likelihood of harm recurring. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- All the people and relatives we spoke with told us staff were often late. One person said, "I have used the service for about three months and at times it has been fantastic, at the moment its bad mainly due to the timings of my calls." A second person said, "When I have consistent carers its spot on, I have nothing to complain about at all, but there are big problems at the weekend, the staff are so overloaded with people to see."
- People told us at weekends their care was rushed, and they did not receive the care they needed. One person said, "I can't wash myself and the carer doesn't spend the time making sure that I am clean. Rather than wash me they use wipes which don't clean properly. They are very rushed and needs to get on to

another call."
● Visit records supported people's views about timeliness of visits. We saw one person getting a call at five fifty-five in the morning, when we asked the registered manager why it was so early, they did not know. We found numerous examples of people receiving early or late calls.
● Visits agreed to be provided at a specific time of day are known as time critical. Time critical care visits are required in order to meet specific assessed needs such as ensuring people receive personal care, support with managing diabetes and for administering medicines. People told us they did not receive their visit at the agreed time. Records confirmed this. This meant their time critical health needs may not have been met, leaving them at risk.
● We found that in the month of July, on one round 24 people had a missed call. On the second route, this number was 22. This meant people went without support on 46 occasions. The registered manager did not have an effective system in place to monitor when calls were missed or late.
● The provider told us they had found recruiting to existing vacancies challenging. They said that staff had left due to the pandemic and other opportunities in the local area made recruitment difficult. They were looking at recruiting from overseas and had obtained the relevant license, however this would take time.

People were not supported by sufficient numbers of staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People and relatives told us medicines were not always managed safely. Some of the people spoken with needed their medicines at a specific time. They told us that regularly these were late. One person said, "I have a regular carer twice a day and when they are on everything is great. This morning they were ill but I wasn't told, I only found out as I have the mobile number and I rang them. The carer who replaced, didn't come till after 11am, no one rang to let me know, I need my medication on time as I am a diabetic but on a weekend its often late." We verified from other people's feedback and call records that other people had also not received their medicines as the times prescribed.
● One relative told us, "I had a problem the other week, staff called the district nurse and they left a prescription for antibiotics. It was a couple of days until someone let me know and we could get the prescription. No one seemed to know what do with it. They also started a new tablet that was dissolvable and none of the carers put it in water, so it wasn't until tablets began to appear on the floor that things changed." We saw through other people's records further occasions where medicines had run out, leading to delays and people not having their medicine as prescribed.
● The provider's incident/accident log had no record of the medicine administration issues relatives and people told us about.
● Although training to administer medicines was provided to staff and competency assessments were undertaken these did not effectively identify and mitigate the risks to people. Staff did not identify that late calls led to time critical medicines being late, errors with administration, or running out of medicines.

Staff did not administer or manage people's medicines safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● People and relatives told us when their regular carer supported them, they were aware of the risks to their health and wellbeing and managed it well. One person said, "On the whole I am very happy with everything, the carers are kind, they usually come on time and do all that I need."
● However, we found when looking at care records that areas of risk were not always identified or assessed when known. For example, in relation to support needs such as dementia, diabetes or skin integrity.

● The provider had not ensured staff were sufficiently skilled and competent to support people safely. Training in key areas such as skin integrity, diabetes, dementia and choking had not been provided, where people had been assessed as requiring support with these needs.
● Staff knowledge of people's health needs was up to date, and they could describe to us the care people required. However, a lack of training together with assessments and care plans not being developed left people at risk of receiving unsafe care. This risk is increased further due to the staffing difficulties the service is facing and that people do not receive care from the same carer.

We found no evidence that people had come to harm, however, people were at risk of harm as assessments and care plans were not in place to mitigate risks to people's health and well-being. Staff had not received training to provide care in a safe manner. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People considered vulnerable did not have individual risk assessments in place with guidance to staff on how to mitigate the risks of spreading or contracting COVID-19.
● Staff had completed infection prevention and control training specifically in relation to COVID-19. Training records confirmed that staff completed donning and doffing training to ensure they knew how to safely put on and remove personal protective equipment [PPE].

We found no evidence that people had come to harm, however infection control processes were not robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that staff wore PPE when caring for them. Staff confirmed there was regular testing carried out and they had enough stocks of PPE available to them.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- An inspection was carried out at another of the providers branches on 18 May 2021. At that inspection we found issues relating to staffing deployment, medicines management and a lack of risk assessments in place for identified health needs. We also found governance systems were not effective in identifying or driving improvements.
- Similar themes were present at this inspection of Primecare Dunstable. The provider and registered manager had not made improvements following the lessons from the inspection at the other location.
- The registered manager and provider had not established systems and processes resulting in the issues found at this inspection. We found systems were not effectively operated to identify and implement improvements. The provider and registered manager did not have an overarching improvement plan that captured the actions arising from audits, complaints, safeguarding concerns etc. This meant they had little oversight in what needed to improve.
- Quality assurance systems in place to assess, monitor and improve the quality of the service were ineffective or not in place. The registered manager told us they did not keep an audit or tracker of incidents, complaints, safeguarding concerns and medicine errors to identify patterns and themes emerging. Similarly, they did not maintain a training overview. We identified at this inspection that staff did not have training in key areas such as skin integrity, continence management, mental capacity and supporting people living with dementia.
- Audits of care records did not identify where risk assessments for areas such as dementia, diabetes or choking were required. Training plans did not ensure staff had the required training in place, such as infection control, dementia, diabetes, COVID-19 or donning and doffing. Neither the provider or registered manager had identified these areas as requiring improvement. The failure to effectively audit and develop risk assessments and training placed people at risk of receiving unsafe care.
- The registered manager completed a monthly report for the local authority that set out how many calls were on time, late and missed. However, as staff did not log in and out when they arrived and left a visit, this report was not accurate. This was because it then reported that staff had stayed the full time, when in fact staff had stayed significantly less time. This also meant the provider was not able to monitor timeliness and review for trends and themes to be able to improve the quality of care. In the minutes of a March 2021 meeting staff discussed the need for visits to be logged in and out and for calls to not be rushed. This did not prompt improvement.
- The provider did not audit the quality of the care provided to people. We asked how they assured themselves the service was safe and requested an audit to demonstrate this. They provided a copy of a local

authority monitoring review and told us they relied upon this to identify where improvements were needed. This was not a robust process of monitoring key areas to improve quality and safety and failed to ensure people received safe care.
● The registered manager failed to notify CQC of safeguarding incidents which may have resulted in people being at risk of harm using the service.
● The management team did not take advantage of the numerous opportunities that were available to them to enable shared learning, reflective practise and development across the organisation. They did not promote a culture of continuous learning and improving care which led to people receiving unsafe care.
● We found breaches of regulation relating to staffing, infection prevention and control, safeguarding, training and support for staff and management. These widespread failings demonstrated the provider did not fully understand regulatory requirements.

Systems were either not in place or sufficiently robust to demonstrate the quality and safety of services was effectively managed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● After this inspection on 17 August 2021 the provider sent us an improvement plan that addressed the areas found at this inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People told us they did not feel the registered manager or provider engaged with them well. People told us they raised concerns to the office and management which were not listened to or resolved. The provider and registered manager were unable to share examples of where they had engaged with the staff team and made changes following their views, opinions or feedback.
● Relatives told us they also did not feel listened to. Feedback had been obtained through a survey in 2020 about the quality of the service. Although overall the feedback was positive, people and relatives had raised their concerns about punctuality and feeling rushed. People's feedback was not acted upon to drive improvement as we found the same issues at this inspection. One relative told us, "I have complained and I felt that at the time my concerns were taken on board but nothing really has changed."
● Care staff told us that team meetings were not being held due to the pandemic. Office meetings were held which had identified in March 2021 that staff were not logging in and out, and calls were rushed. Information was then shared with staff by email and messaging systems; however, this did not give staff an opportunity to raise their views or opinions, share ideas, or hear about wider issues concerning the management of the service.

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
● People and relatives told us the registered manager and provider were not responsive to issues and concerns. They told us when they raised concerns these were acknowledged but very little changed, and they did not receive an explanation or apology.
● One person told us, "If I ring the office it depends who answers as to whether I feel listened too or not. I regularly ring to see which carer is coming and I have asked for a rota with no joy." One person told us their visit happened, but the call times were sporadic and they were not sure how long the carer should stay for. They said they did not know what time the carer should come, so sat anticipating their arrival. When asked if they felt they could complain they told us they did not want to do so, as they were simply grateful to have the visits at all. People's experiences did not demonstrate an open and honest culture where people were able to safely raise their concerns and be confident they would be remedied.
● Duty of candour sets out some specific requirements that providers must follow when things go wrong

with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records, discussions with staff or management to demonstrate where this had occurred.

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 Safe Care and Treatment Regulation 12 (1) (2) (a) (c) People were at risk of harm as assessments and care plans were not in place to mitigate risks to people's health and well-being. Staff had not received training to provide care in a safe manner. People's medicines were not administered or managed in a safe manner and in accordance with the prescribers instructions. People were not protected from the risks associated with COVID-19.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Systems were not in place to ensure learning was shared from any such allegations or evidence of harm occurring.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing
Regulation 18 (1)

Sufficient numbers of suitably competent and experienced staff were not deployed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance Regulation 17 (a) (b) (e) & (f) The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not seek and act on feedback from people, staff and other persons on the services provided for the purpose of continually evaluating and improving. The provider did not evaluate their practice to continually monitor, develop and improve the quality of care people received.

The enforcement action we took:

We issued a warning notice to ensure the provider made the required improvements and people would receive safe care that was well managed.