Premier Care Limited

Premier Care Limited - Trafford & Manchester Learning Disabilities Branch

Inspection report

8 Premier Street
Old Trafford
Manchester
M16 9ND
Tel: 0161 226 2270
Website: www.prem-care.co.uk

Date of inspection visit: 21 January 2015
Date of publication: 08/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Premier Care Limited - Trafford & Manchester Learning Disabilities Branch on 21 January 2015. We gave 24 hours' notice of the inspection.

The previous inspection had taken place on 16 April 2013 when we found no breaches of the regulations we looked at.

Summary of findings

The service supported people with learning disabilities who live in six separate houses around Trafford. At the time of our inspection 13 people were being supported by the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Each house had one member of staff on duty supporting up to three people. Sometimes the staff worked very long shifts including a night shift when they could sleep. Staff members told us the long shifts did not affect their ability to provide care and support.

Checks on new staff were conducted. Staff were well trained in all areas including safeguarding. Medication was administered safely.

We considered that one person's freedom was being restricted without their consent. We understood the restriction was intended for the person's benefit and safety. Nevertheless this was a breach of a regulation made under the Health and Social Care Act 2008, regarding obtaining and acting in accordance with consent. You can see what action we told the provider to take at the end of the full version of the report.

We saw that staff had built up caring relationships with the people they were supporting, in some cases over many years. People were encouraged to become more independent.

A wide variety of activities was available. Some people were encouraged to work in the community.

The registered manager involved staff in generating improvements. However, the questionnaires used for staff and also the questionnaires used for people using the service and their relatives needed improvement. There were monthly reviews by the directors but no evidence of these was made available. Trafford Council was intending to change the provider of the service, but this was not related to any performance issues of the current provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff on duty in each of the houses, although some staff worked very long shifts.

Checks were made when recruiting staff to ensure that only suitable staff were employed.

People told us they were happy and felt safe. Staff were trained in safeguarding. Medication was administered safely.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

Staff were skilled and experienced. New staff received a thorough induction and all staff received ongoing training. Staff received regular supervision and support.

Consent was not always sought for restrictions imposed on people.

People were helped to eat a healthy diet. The service ensured people saw health professionals regularly.

Is the service caring?

Good

The service was caring. Staff had built up close relationships with people they were supporting, sometimes over many years.

People were encouraged to develop their independence and to acquire new skills.

People's privacy and dignity were maintained. Staff ensured that people understood the purpose of our inspection.

Is the service responsive?

Good

The service was responsive. Care plans were person-centred, which meant they responded to each person's individual needs.

The care plans we saw had been written within the last 12 months. Relatives told us they were informed about changes to care plans.

There was a wide variety of activities available, which took into account people's abilities. Some people had jobs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Family members and other professionals spoke highly of the management.

Summary of findings

Team leaders and support workers were encouraged to contribute ideas for improvements. The directors conducted monthly reviews but no records of these were available.

There were questionnaires for both staff and people using the service, but these needed to be improved.

Premier Care Limited - Trafford & Manchester Learning Disabilities Branch

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 21 January 2015. We gave 24 hours' notice of the inspection. This was because it is a small service and we wanted to ensure the registered manager was available. We also wanted to arrange to visit some of the houses where people supported by the service lived. The inspection was carried out by an inspector from the adult social care directorate of the Care Quality Commission (CQC).

Prior to the inspection the service had submitted 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 also contacted the officer of Trafford Council who had oversight of the council's contracts with the service.

On the day of the inspection we talked with the registered manager and the deputy manager about the management of the service and related issues. Then we visited three of the six houses where people supported by the service were living. We talked with five people in these three houses, and with a member of staff in each house. We looked at four care files. We also looked at other records relating to recruitment, training, audits and staff meetings. We took away copies of some documents we had requested. We discussed our findings with the registered manager and the deputy manager.

After the inspection we spoke with two relatives of people supported by the service. We also spoke with the reviewing officer of the Trafford Community Learning Disabilities Team who had specific responsibility for assessing this service.

Good

Is the service safe?

Our findings

This branch of Premier Care was supporting 13 people living in six separate houses in different parts of Trafford. In each of the six houses there was one member of staff on duty at all times. One of the houses had two members of staff during the daytime. We saw staff rotas for the week of our inspection and the week before, which confirmed this. The manager and deputy manager explained that this was sufficient staff to meet the needs of people living in the houses. We visited three of the houses, two of which had three people living there, and the third had one person. Our observation, based on the needs of the people who were being supported, was that in each of these houses one member of staff was sufficient. Staff told us that in the event of any emergency they could call one of the managers, day or night.

Usually staff worked in the same house, which enabled people living in that house to build up confidence and familiarity with those staff, and vice versa. A few staff worked regularly in more than one house. All the staff were familiar with all the people using the service so that in the event of staff being absent another member of staff filling in would know the people in the house already. The staff we spoke with confirmed this was the case. One family member commented favourably that the service now rarely used agency staff (who would not know the people using the service).

Each of the houses had a staff bedroom, which in some houses doubled as the staff office. The night shift from 11pm to 7am was described as a 'sleeping night' and staff were meant to sleep. Staff told us that they generally did sleep through the night and they were not disturbed.

We noted that some of the periods on duty were very long, for example up to 33½ hours in all. Periods of 24 hours or more were common in each of the houses. Even allowing for the eight hours' sleep during the night shift these long consecutive shifts were likely to affect staff members' ability to work effectively and to look after the people they were supporting. However, staff did not complain to us about the length of time they were on duty. The work was not usually physically demanding and people told us they were happy with their rotas. Nevertheless the service ought to reconsider this practice of multiple consecutive shifts in the light of the Working Time Directive.

We looked at three staff recruitment files to check that all the necessary procedures had taken place to ensure staff were both well qualified and suitable to work with the vulnerable people supported by the service. There was a checklist at the front of each file which made it easy to see that all necessary documents had been obtained as part of the recruitment process. The file was then signed by the registered manager to confirm that she had checked it. The application form asked for reasons for any gaps in the employment record. We observed that one job applicant, who became an employee, had not put any dates of previous employment on their application form. We asked the deputy manager about this who said this particular person had not worked for a long period before starting with Premier Care. The deputy manager had therefore obtained personal references and was satisfied as to the person's suitability from these references.

We spoke with five people supported by Premier Care who lived in the three different houses we visited. We asked them whether they felt safe and they all replied positively. One person said: "Yes I feel safe. Since I've been here I have had no problems. If I had any problem I would go and see one of the managers."

Another person said "I'm happy. There has been no bullying in the house." They and the team leader recalled an incident that had taken place away from the house at a day centre, where someone attending the day centre had put the person under pressure to do something they did not want, but this had been resolved, with the active involvement of the team leader. We asked the people whether they knew what to do if they felt unsafe or felt that they were being treated unfairly. They both responded that they would tell the team leader at once, or another member of staff. When asked further what they would do if it was the staff or the team leader who was treating them unfairly, they were a little uncertain but when prompted said they would tell the manager or the deputy manager. We asked how they would do this, and the team leader told us that each person had a card in their bedroom with the office phone number on it. This meant that people in this house were in theory enabled to raise issues with the management, although in practice they would probably need help to do so. In another house we visited the office phone number was not readily accessible.

One person in one of the houses had a job which they travelled to on their own. This degree of independence was

Good

Is the service safe?

risk assessed and the assessment recorded on the care file. The service was not averse to allowing a degree of risk. Other people were assessed as not being safe if they went out on their own. One person told us they could go out as long as someone went with them. This happened when staff were available to go out with one person or two people at the same time.

We obtained a copy of the induction programme for new staff and saw that safeguarding was included as an 'induction standard'. This meant that all new staff received basic training in the principles of safeguarding vulnerable adults. The programme stressed, that "abuse is a complicated and serious area. Workers will need to develop their skills and knowledge during the induction period but also whilst they are working." We saw records showing that all members of staff had received refresher training in safeguarding during 2014. We asked the staff we met in the three houses about their understanding of safeguarding, and their replies showed they had a good awareness of what constituted the various forms of abuse, how to recognise it and how to report it.

During our visits to the three houses we were shown round and saw that the houses were well designed for the needs of their occupants, and were safe and comfortable. Fire exits were clearly marked and fire procedures recorded. We did see two safety issues in one house, namely a loose banister rail and loose wardrobe doors. The staff member told us the banister had been like that for about 10 days, and they were awaiting the maintenance man to fix it. This shows that action was taken to report a fault, although in this instance the action to complete the repair was not prompt.

Medication was delivered to and stored in the individual houses. It was stored in locked cabinets in the staff office. We saw that when medication was given it was recorded on a 'Medication Administration Report' (MAR). There was a key which identified every staff member who recorded the administration of the medication in case of any later query. These MARs were checked regularly by one of the managers who signed their initials to confirm they had checked. On each MAR was a photograph of the person receiving the medication, together with a photograph of the tablet or tablets. This provided an extra safeguard to ensure that the right medication was being given to the right person.

Requires Improvement

Is the service effective?

Our findings

Many of the staff supporting people in the houses run by Premier Care had worked for the company for many years. This meant they had built up considerable experience and skills in understanding the particular needs of the people they were supporting. In particular many of the team leaders had worked in the same house and with the same people for five or six years or longer.

One family member, who was a frequent visitor, told us that the team leader "has so much patience. They're like an angel sent from Heaven." They added: "The carers are so good with [my relative] all the time. I don't know where they've picked them from - they're wonderful. They use their common sense. I'm so happy there are such good people looking after him."

We obtained a copy of the staff welcome pack which included an induction programme which was being used for all new support staff. This covered eight core areas termed 'Induction standards' which represented the basics that a care worker in this field should know. The pack included worksheets to help assess new workers' understanding of their new learning. The induction programme was six days of training spread over the first 12 weeks (the probationary period). This meant that staff would gain practical experience alongside their formal training. We saw on staff personnel files that the progress of new recruits through this induction course was monitored. Premier Care recorded in the PIR that they intended to extend the first three days of the induction programme to five days. This showed the emphasis that the provider placed on effective induction training.

After their induction, and on a continuing basis, staff received refresher training in seven core areas: basic life support including first aid, food hygiene awareness, health and safety, infection control, medication, moving and handling and safeguarding. We saw records for all the staff employed, including team leaders, which showed that all staff had completed training in these areas within the previous twelve months.

According to these records staff had not received specific training on the Mental Capacity Act 2005 (MCA). The manager told us in the PIR that the service had policies and procedures relating to the MCA. The MCA includes provisions relating to obtaining consent to care and treatment, and what to do if the person is assessed as not capable of consenting to a particular decision. Although the people we met were capable of consenting to most of the decisions affecting their day to day lives, there were some major decisions with which they might need support, and their capacity might vary over time. There were also other people whose capacity and ability to communicate, we understood, was more limited.

We saw that consent was recorded on care plans, for example for photographs to be used on the care plan. We saw that one person had declined to give consent for a new photograph to be used, but had agreed that an older photograph of themselves could be used. This showed that care had been taken to secure consent.

In this context we saw that one person who was generally able to go out and about on their own was required to be back in their house by 11pm every night. The person told us they knew about this restriction but had not agreed to it. There was no record on their care plan that they had consented to it, and there was no reference in the risk assessment to the reasons why this restriction was in place. There was a statement in the care plan, written in the first person, saying: "I know I should get home by 11pm, but sometimes I want to stay out and don't want to come home." Below this were instructions to staff as to what steps to take in case the person was not home by 11pm.

We discussed our findings with the registered manager and deputy manager. They told us there were good reasons for the restriction, and that it was in the person's best interests. It was likely that the person did have capacity to consent to or refuse the restriction. However, in the absence of any record of consent, or any mental capacity assessment, it was open to question whether the restriction was contrary to the person's human rights. The failure to obtain or record consent was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular supervision of staff took place. We saw records showing that each support worker received supervision from one of the management team every three months. Also at three month intervals management conducted a spot check which involved observing the support worker with people they were supporting. There were regular house meetings which offered staff the opportunity to

Requires Improvement

Is the service effective?

discuss issues in their individual houses. We also saw that annual appraisals had taken place for all staff in the last few months of 2014. An appraisal is an opportunity for a staff member to look back at achievements in the preceding 12 months and to set goals for the year ahead.

The kitchens we saw in the houses were well equipped. Generally the staff prepared meals, but people told us they liked to be involved with menu choices and assisted with meal preparation. One person told us they did most of their own cooking. They had taken cookery classes at a local college, although funding to attend there had recently ceased. The staff told us they took care to ensure that people ate a balanced diet, and catered for special dietary needs.

Each person had a health action plan which included a description of healthy eating for that person. It also included a record of visits to the GP, optician, dentist, chiropodist, other health appointments and the annual disability health check (a health check for adults with learning disabilities). We saw that these visits were facilitated and recorded, in order to maintain people's health.

Good

Is the service caring?

Our findings

Staff told us, and it was clear from our observations, that they had built up close supportive relationships with the people living in the house they worked in. Staff members had worked with the same people in some cases for many years. There was an easy-going banter between people living in the houses and the staff. One relative said of a team leader: "They are beyond good. They know the people really well, and anticipate what they need. The team leader works with great care and compassion. I can't praise them enough." Another family member said: "My relative sees the staff as their friends. The staff give them a great level of emotional support."

Premier Care sets out in its mission statement that it believes in "enhancing quality of life by preserving independence, dignity and privacy and promoting autonomy and personal choice." We saw that staff tried hard to put these principles into practice. They treated people respectfully, for example by asking their permission before showing us their bedrooms. They sought to develop people's capacity to look after themselves. Part of each care file was a 'development log' which recorded progress and goals in various areas. For example on one file under the heading 'skills for everyday life' was a description of how the person should be encouraged and supervised to brush their teeth. Another goal was to learn to mop the floors, another how to make a pasta bake successfully. This person told us they also did their own washing and said: "I choose to do it." It was clear this person's specific needs had been identified and their acquisition of new skills was supported.

A family member commented favourably on the level of independence that their relative had gained while being supported by Premier Care. They were now using the washing machine, helping with the cooking, and had attended college for three years. "The staff encourage [my relative] to be independent. They have benefited so much. They are a different person now."

One person told us: "I come and go as I please." Another person who had a regular job at weekends told us they went to work on their own, and had a key to get back into the house. This meant that their independence was promoted, and the person was clearly proud to tell us about their job and self sufficiency.

One person told us they were not allowed to smoke in the house because it would make the paint and curtains go yellow. We saw that they went out onto the front path to smoke. The house was of course this person's home. Although this was an infringement of their personal liberty it was one that they had the capacity to consent to and agreed with. They told us: "I'm happy with that."

The houses we visited were comfortable and homely, and well suited to the needs of people living there. Each person had decorated their own bedroom. There were photographs on the walls; in one house photographs of the three occupants were in most of the rooms, showing a family atmosphere had been created. We were told that in one house the three young adults had grown up together from childhood, and had very close bonds. This enhanced people's wellbeing.

We saw that staff took trouble to explain things to the people they were supporting. For example they helped people to understand the purpose of our visit. During one conversation with two people, the staff member helped to explain our questions and ensure that they understood them and that we understood their answers.

Good

Is the service responsive?

Our findings

Care files were kept in the individual houses where people lived and copies were kept in the office. This allowed staff to consult the files whenever they needed to. Each person had two files: a 'development log' which included daily logs, and a home file which stored more permanent documents including the care plan and health action plan.

The care plans were entitled "My person centred plan". They were written in the first person. We read two care plans in detail and considered that the members of staff who wrote them demonstrated personal knowledge of the individual and their needs. The plans had multiple sections covering different aspects of that person's life.

There was space for the person using the service to sign on the care plan, although it was not clear what they were signing for - whether to show they had contributed to the writing of the plan or just that it had been shown to them. On one file there was a signature to acknowledge receipt of the service user guide, but we did not see that on each file. We noted that there was no indication on the files that they had been reviewed, but the ones we looked at were all dated within the past seven months. Two of those related to people whom Premier Care had supported in the same accommodation for many years. Evidently the provider's policy was to rewrite the care plans rather than update them.

We asked family members whether they had been involved in reviews of care plans. One person told us they were made aware of any changes, but could not recall being consulted about changes that were planned. They also could not recall receiving a questionnaire to ask about their perceptions of the service. They stated, however, that they regularly saw the team leader in the house where their relative was living, and would raise any issues directly with them.

We noted that one person's file included a missing person's form, which would be handed to the police or other official in the event of them going missing. That form, and another one on a form to be handed to ambulance personnel, included the person's previous address, as did their NHS card. The person had moved into their current address about nine months earlier, so updates to these documents were overdue.

Each person had an 'activity planner' and a 'menu planner' which were not in fact planners, but a record of their activities and food intake respectively. People were encouraged to take part in activities both inside and outside their homes, according to their abilities and interests. One person had a mobile gym in their bedroom, and told us they used it quite often. In another house there was a dartboard, a pool table, table football and board games such as Scrabble. One person told us they went out on their own and enjoyed visiting museums. We spoke to a family member who said "They're always out and about."

One person, with help from a staff member, described to us their weekly activities. They attended drama club, football, IT sessions, gardening club (weather permitting), cookery class, circuit training and once a month a night club. This represented a full range of activities. Not everyone could or wanted to take part in such a range of activities, but appropriate ones were available and staff supported people to take part. These activities were all recorded on people's activity planners.

People in one house had been on holiday to Cornwall last year, and proudly showed us the photographs.

We met one person who had a part time job at weekends, and another person was out working during our visit. Their job was four days a week. Staff told us that they had helped facilitate this person obtaining this employment. Initially the staff had accompanied one person on the bus to and from work, but they were now capable of making the journey on their own.

The people we met told us they would talk to their team leader if they had any complaints. Information on how to make a formal complaint was in the Statement of Purpose - a document which sets out briefly the aims of the service. We saw the complaints policy and procedure. In the previous 12 months the service had not received any complaints under its formal complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The mission statement of the service stated: "Our aim is to provide the highest quality care to Service Users who wish to remain in their own homes but would be unable to do so without support." Our perception was that the staff of Premier Care, in particular the support workers and team leaders in each house, had grasped this vision and were striving to put it into effect.

One family member praised the management, saying: "The managers are very receptive and caring. They are very professional." The service benefited from having a registered manager with many years' experience and a deputy manager. We knew from some information which had been sent to us that one or both managers became involved in any issue that arose within one of the houses, and went out to establish what had happened and reassure people as appropriate. The deputy manager conducted monthly spot checks of each house which included looking at health and safety issues.

At our inspection the registered manager gave an example of the management responding to events. On a bank holiday weekend in 2014 one house had run out of MAR (Medication Administration Report) sheets, which had caused problems with recording. The management had responded by devising a new policy addressing what to do in similar circumstances. The problem had not recurred.

We spoke with a member of the Community Learning Disabilities Team of Trafford Council, who was responsible for reviewing the service. They told us they went out annually to each of the houses. In many cases they had been involved in arranging where the person would live. They said that Premier Care was a well managed service. "I have never found any major issues." They did comment that sometimes they or a colleague wrote a report, and sent a copy to Premier Care, but it was not placed on the person's care file for staff and other professionals to see. This might mean the staff then did not have access to all the information needed to be able to understand people's needs.

Staff meetings were held with all the team leaders roughly every two months. We saw minutes of these. The team leaders then held meetings with the staff in individual houses. This meant that all staff were involved in the decision making process.

The service used a "Quality Assurance Questionnaire" for support staff which they could complete anonymously if they wanted to. The questionnaire included questions on a wide range of topics: quality of the service, support of staff, training, policies and procedures, privacy and complaints and safeguarding. There was also a box for free text comments about the service and any suggested improvements. We did not see completed copies of this questionnaire. We felt this was a good way of acting transparently and allowing staff to influence the way the service was run. We also considered there were improvements that could be made to the questionnaire. There were numerous typographical and grammatical errors which made the questions harder to understand. Whilst making the questionnaire so concise would encourage staff to complete it, there was scope for more detailed questions which might produce more useful responses.

We were shown a similar annual survey intended for people using the service. People could be helped to complete such a questionnaire by staff or family members. However the questions in this survey appeared to relate to a different sort of service, namely a domiciliary care agency, when care workers visit people in their homes. For example it asked "Does your carer arrive at the time you expect them to?" and "When your carer arrives, do they do the duties on your Care Plan?"

At the management level the registered manager told us in the Provider Information Return that there were "monthly formal documented reviews of the branch with the directors". We asked to see records of these reviews but were told firstly that the directors kept these, and later that there were no records available. For such reviews or audits to be an effective exercise in improving the standards of the service, records ought to be available for the managers so that they could be able to monitor the quality of the service.

At the inspection we learnt that Trafford Council had carried out an exercise to tender the service and allow other providers to bid to provide it. The motivation for this was not connected to the performance of the current provider. Following the inspection we learnt that another provider had been successful in winning the contract from April 2015.

Requires Improvement

Is the service well-led?

The staff had been told that in the event of a new provider they would be able to keep their jobs under TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006). There was no guarantee that they would remain working in the same houses.

People using the service had received letters telling them the organisation providing the service might change. Some of them told us they did not know what was going to happen. Relatives also expressed some concerns.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider had not always ensured there were suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care, treatment and support provided for them.