Supreme Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Supreme Care Services is a domiciliary care agency providing personal care and support to people in their own homes. Not everyone who used the service received personal care. At the time of the inspection 335 people were receiving personal care. The Care Quality Commission 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.

People's experience of using this service and what we found
People and their relatives told us they did not always feel the support provided was safe. Not all staff understood the provider's procedure to keep people safe from abuse.

Staff were not always deployed effectively to ensure care visits were carried out on time. When this happened people told us there was not enough time to wash and they felt stressed. People who needed care from two members of staff told us staff would always wait until both members had arrived to ensure care was delivered safely.

People and their relatives told us they were treated with kindness by their regular care staff, however, the service did not always provide people with care staff who spoke their language. Staff told us how they developed compassionate relationships with people and used body language and pictures to better communicate with people.

The service was not always well-led. People and their relatives told us communication with the office was unsatisfactory and they had not been contacted about their views of the care provided. The service's monitoring system did not always identify concerns with care delivery. External professionals told us that the service did not always work with them effectively to keep people safe.

Staff told us the management of the service was effective and they felt they were kept up to date with any changes. We were assured by the service's measures to prevent and control the spread of infection.

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 24 September 2019).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about keeping people safe from abuse. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with keeping people safe and good governance, so we

widened the scope of the inspection to become a focused inspection which included the key question of well-led.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches in relation to safeguarding people from abuse and good governance at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Supreme Care Services Limited

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on a specific concern we had about keeping people safe from abuse. We inspected and found there was a concern with keeping people safe and good governance, so we widened the scope of the inspection to become a focused inspection which included the key question of well-led.

Inspection team
The inspection team consisted of one inspector and two Experts 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 they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
Notice of inspection
This inspection was unannounced.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three members of staff including the registered manager, branch manager and call monitoring manager. We reviewed a range of records. This included seven people's care records and a variety of records relating to the management of the service.

After the inspection
We spoke with 12 people who use the service and 13 relatives of people who used the service. We spoke with 12 members of care staff. We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and other records relating to the management of the service. We spoke with professionals from two local authorities who commission care from the service.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about safeguarding people from abuse. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

● The provider's systems were not set up to ensure people were always safeguarded from the risk of abuse. We received mixed feedback from people and relatives of people using the service about their safety. One person said, "I feel unsafe", a relative said, "They take advantage of vulnerable people, we cannot trust them." Conversely, positive comments included, "[My relative] is 100% safe…they pay [them] a lot of attention and her needs are met."

● Despite training, staff did not always understand the provider's system to safeguard people from abuse. For example, staff we spoke with told us they would talk to a colleague they saw harming someone rather than reporting it to their manager. Staff told us the training they had been on was not adequate for them to understand what to do.

● Staff did not always know how to blow the whistle on poor practice by reporting their concerns to outside organisations. One staff member said, "I don't know anything about whistleblowing." A second said, "I think whistleblowing is like fire emergency or any hazard." Feedback from external agencies included a report that allegations of harm were not reported in a timely manner as stated in the provider's policy.

The above issues amount to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other staff demonstrated a clear understanding of the provider's safeguarding procedure. One staff member told us, "If you notice any issues with the service user you send it to office who will escalate to the manager and senior management then to social services if necessary. Abusing somebody is contrary to the spirit of caring. It is so wrong".

Staffing and recruitment

● The service did not deploy staff effectively meaning people did not always receive their care on time. People affected told us this had a negative impact on their wellbeing as they did not receive all the care they required. One relative said, "'My [family member] feels unsafe because they don't complete their job properly and leave the floor wet."

● We reviewed the call monitoring system for the three weeks preceding the inspection date. We found that 22% of visits were more than 15 minutes late.

We recommend the service seek support and advice from reputable sources about staff and punctuality.

● Staff told us there were enough staff to meet people's needs and they wait for their colleague before supporting people who required two members of staff. Records showed people and relatives were called when staff were running late. However, people reported they had not always been informed about staff lateness.
● The registered manager told us they had reorganised the rota to ensure staff had less far to travel. Staff told us they preferred the new rotas. Additionally, the registered manager told us they had created care bubbles to keep service users care visits limited to a bubble, but this may have impacted on punctuality.

Preventing and controlling infection
● We were assured by the provider's measures to prevent and control the spread of infection and the service was following national guidance.
● The provider had trained staff about infection control and how to use personal protective equipment (PPE) safely. People and their relatives told us staff always wore PPE and had good hand hygiene. People's relatives told us staff supported people to wash their hands where appropriate.
● The provider encouraged staff to test for COVID-19 and staff did not work if they had a positive test result.

Inspected but not rated

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check a specific concern we had about the way people were treated. We will assess all of the key question at the next comprehensive inspection of the service.

Ensuring people are well treated and supported; respecting equality and diversity

- People's diversity was not always respected because people and relatives told us staff did not always speak the person's language. One relative said, "the company needs to offer culturally sensitive service to cater for individual's needs."
- Following the inspection the registered manager told us that they were always open and transparent if they could not provider a carer who could converse in the person's language, thus giving the Council and the service user the choice to seek an alternative provider.
- In other instances, people told us staff were adept at using body language to better communicate with them and understand their care needs. One family member said, "Some care staff are very good and they became part of our family. Now my [relative] has a regular carer, which is continuity of care, although they don't speak the language but speak slowly so [relative] can understand through their body language."
- People were well treated by their regular care staff. People and their relatives told us they were kind and friendly. One person said, "Carers are friendly and polite." A second said, "The carers are kind they are like my daughter."
- Staff spoke warmly of people and told us how they developed caring relationships with the people they supported. One staff member said, "I try to find out what their need are, find out what makes them happy, build their confidence and trust in you and have repour with them". A second explained how they got to know people who were non-verbal. One said, "I check their expression to know if they are feeling any pain, sad or happy. Some people use the pictorial cards to point out what they want you to do and how to help them or what they want to eat. You must be very attentive."

Requires Improvement

Is the service well-led?

Our findings

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

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

At the last inspection we recommended the provider review the quality of communication people and relatives have with office staff. Not enough improvement had been made in this area.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The service was not always open and inclusive. People and their relatives told us poor communication with the office had a negative impact on people's mental health. One relative said, "The communication channel is very poor when carers are running late or they don't turn up they don't inform us…the office staff blame each other. They can't be bothered and don't understand how it will effect on people with complex needs." A second person said, "A [staff member] in the office has a poor telephone manner, no people skills, [they] answer the phone chewing and eating something. I rang yesterday and asked [them] to let me know what carers would be visiting me. She told me that it depended on how busy [staff member] was." A relative said, "Every time I rang I received an unprofessional service. They told me they would call me back but they never did. There is a lack of awareness about what is going on with the clients and they don't resolve problems".
- The registered manager told us they have a policy to answer calls to the office by the third ring, however no monitoring records were provided to evidence this.

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

- The provider's governance systems were not set up in a way to consistently identify concerns and use them to drive improvements in care delivery. For example, records showing that people were informed of staff lateness contrasted with people telling us they were not always informed. One relative said, "it would be nice if they can inform us if carers are running late or replaced with other care staff." High levels of late calls were not used to drive forward punctuality and were not monitored to assess whether people identified as high risk were consistently late.
- Internal audits and mock inspections did not highlight the safeguarding concerns found during the inspection. A recent audit found there were no actions required to improve the system to protect people from the risk of harm.
- People, their relatives and staff told us the service was managed by the branch manager and the registered manager was more senior to the day to day running of the service. The registered manager was not on site when we arrived on the day of the inspection and told us they worked from the head office for

part of the week and alternate days at this service; and that they worked well with the branch manager to run the service. A health and social care professional we spoke with found that they were routinely unable to contact the registered manager at the service.

● In response to the pandemic, the registered manager had taken on the role of infection control lead in addition to their existing roles of safeguarding lead and registered manager for the service.

● Feedback from people and their relatives regarding the management of the service was mixed with some saying the set up needed to be improved. A relative said, "I've spoken to the [branch] manager to tell [them] that they must let me know of any changes, the carers arrive much too late, but nothing has changed". A second said, "the management is very disorganised. We noticed their administration and time keeping is getting poorer, but they never let us go without a carer." Positive comments included, "I don't know the manager, but my general opinion is that the service is excellent."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider did not always fully engage with people using the service. For example, records demonstrated the provider had held monitoring telephone calls and spot checks to check the quality of care however people and relatives told us they hadn't been contacted. A person said, "they never invited me for any meetings, never received any questionnaire and I haven't seen any spot checks." A relative said, "I received a questionnaire a long time ago, but haven't attended any meeting and not aware of any spot checks."

● The registered manager said they were contacting people who they deemed at high risk on a monthly basis however, the telephone monitoring records did not demonstrate this.

● People and their relatives told us the service did not always listen and act on their concerns. A person told us, "I was not happy with the service because my needs were not met and I discussed it with the manager but there was no improvement."

● The registered manager told us the duty of candour was to be, "Open and transparent with them about what things go wrong", and that they worked well with external agencies. However, external professionals reported there was a lack of responsiveness to their enquiries from the service and the provider had failed to notify them and the CQC of an allegation of abuse in a timely fashion.

The above issues amount to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt well supported by the service and reported that communication was good. One staff member said, "I feel supported to raise any concerns. The registered manager and my immediate manager encourage us to raise concerns and they will always take action". Staff attended regular team meetings where the latest changes in national guidance were discussed.

● Staff we spoke with told us that management conducted spot checks to check staff performance. Staff felt they were well supported by the management team.

● One local authority commented positively on the ability of the provider to continue to provide care during waves one and two of the COVID pandemic.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems to protect people from abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems were not effective to assess and improve the quality and safety of the service including the quality of people's experience of the service.