

Premier Care Limited

Premier Care Blackpool Branch

Inspection report

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16 June 2020
23 June 2020

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Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inspected but not rated

Is the service well-led?

Inspected but not rated

Summary of findings

Overall summary

About the service

Premier Care Blackpool Branch provides personal care and support to people living in their own homes within the Blackpool area. In addition to providing a domiciliary care service, the registered provider also manages two supported living homes for people with learning disabilities and people with mental health needs.

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.

People's experience of using this service and what we found

People told us they were supported by staff who knew them well. On the whole people within the domiciliary service told us they were happy with how their visits were planned and coordinated. Staff said they were not rushed. Although people told us they felt safe whilst being supported by Premier Care Blackpool Branch, the service was not safe. Medicines were not always managed safely and in line with good practice. Risk was not consistently identified, addressed and reduced. Staff did not always have the correct skills required to promote safety. The organisation had a safeguarding policy, but we could not be assured this had been fully implemented to keep people safe from the risk of abuse and harm.

On the whole, people told us they were happy with how the service was managed. However, we identified a number of failings regarding the oversight and governance of the service. Policies and procedures were not always consistently followed to maintain safety. For example, safeguarding, managing accident and incidents and staff training procedures were not consistently followed. Records were not always accurate, up to date and reflective of people's needs. Not all documents we requested to see were made available to us. We reviewed eleven care records and identified concerns within ten of them. In addition, the registered provider failed to show they worked proactively with health professionals to ensure guidance was followed to keep people safe.

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

Rating at last inspection

This service was registered with us on 04/04/2019 and this is the first inspection.

Why we inspected

We received concerns in relation to the management of medicines and management of risk. 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. We have found evidence that the provider needs to make

improvement. Please see the safe and well-led sections of this full report.

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 have identified breaches in relation to management of risk, management of medicines 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 meet with the provider following this report being published to discuss what improvements they intend to make to ensure people are safe and the service is effectively governed. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We have not reviewed the rating at this inspection.

Inspected but not rated

Is the service well-led?

We have not reviewed the rating at this inspection.

Inspected but not rated

Premier Care Blackpool Branch

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection team was made up of two inspectors, one assistant inspector and a pharmacist specialist. One inspector and the pharmacist specialist visited the office location to gather information and speak with staff. One inspector and assistant inspector supported the inspection team by making telephone calls to people who used the service, relatives and staff.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. In addition, this service provides care and support to people living in two supported living settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

We informed the service of our visit the day before the inspection. This was because we needed to be sure the environment was safe to visit due to covid-19 pressures and to ensure there was someone at the office who could assist us with the inspection process.

Inspection activity started on 16 June 2020 and ended on 30 June 2020. We visited the office location on 16 June 2020 and 23 June 2020. Because of risks associated with Covid-19, we were unable to visit people in their own homes. Information was collected through telephone calls and viewing records at the office.

What we did before the inspection

We reviewed information received from the registered provider to demonstrate how they were managing people's medicines. In addition, we looked at what information we had received about the service since it was registered with the Care Quality Commission in April 2019. This included looking at information held on our database about the service for example, statutory notifications completed by the registered provider and safeguarding concerns reported to the local authority. We took this into account when we inspected the service and made the judgements in this report.

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 also sought feedback from Lancashire and Blackpool contracts and commissioning teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with 15 people and two relatives. In addition, we spoke with the area manager, the registered manager, the head of governance, a care coordinator, a medicines coordinator, and eleven members of staff responsible for providing direct care.

To gather information, we looked at a variety of records. This included care records related to eleven people, and multiple medicines administration records. We also looked at information related to the management of the service. These included audits, the training matrix and quality assurance documents. We did this to check the management team had oversight of the service and to make sure the service was appropriately managed.

Following the office visits we also spoke with six health and social care professionals and a community pharmacist. We did this to get their feedback on how the service was run.

After the inspection

Following the inspection, we spoke with the registered provider to corroborate our findings. We liaised with the local authority safeguarding team and contracts and commissioning teams to share our findings and raise concerns identified during the inspection process.

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. We have not reviewed the rating at this inspection. However, we found people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not consistently managed. Directions for the safe administration of medicines were not consistently followed. For example, one medicine had been identified by the registered provider as a high-risk medicine to be given 30-60 minutes before food. We reviewed four MAR records and saw these instructions were not being followed and no one had identified this as a concern.
- Not all medicines were being administered orally. When medicines were being administered by an alternative route, we could not be fully assured advice and guidance had been sought from a pharmacist to ensure medicines were being safely administered.
- When risks regarding misuse of medicines had been identified, medicines were not always consistently stored securely to prevent further misuse.
- We could not be assured people received medicines in line with good practice. We found missed signatures on MAR's. In addition, stock counts of medicines did not always match information on the MAR record.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back concerns to the registered provider so immediate action could be taken. Following the inspection visit we received confirmation a pharmacist would be supporting the organisation to look at improvements.

Assessing risk, safety monitoring and management

- Although people who used the service told us they felt safe, individual risk was not always suitably addressed and managed. People were sometimes exposed to risk of harm.
- The registered manager had failed to identify, and address risks associated with falls. We reviewed care records for one person who was deemed at high risk of falling. No systems had been implemented to provide us with assurances that risk had been reviewed and mitigated.
- Two people were identified as at risk of choking. Documentation to support staff to manage the risk of choking was not always available or followed. Health professional guidance was not always sought in a timely manner.
- When people had displayed behaviours which sometimes challenged the service, reporting processes had not always been followed. Care plans and risk assessments had not been updated to reflect any risks presented and how to mitigate risk.

- Staff had not been consistently provided with training to enable them to understand and manage risk. One person had complex health care needs. We were not assured staff had received the correct training to manage the risks associated with the care and treatment of the person's medical condition. Specific training as highlighted in the organisation's medicines policy to meet the needs of the person had not been completed. In addition, staff working with people with an unsafe swallow reflex confirmed they had not had specialist training to safely manage this condition.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we raised concerns with the nominated individual so action could be taken. We were not assured all risks had been reviewed and addressed. We raised safeguarding alerts to the local authority when people were deemed at risk of harm.

Learning lessons when things go wrong

- We could not be assured lessons were learned from accidents and incident which arose within the service. During the inspection visit, we asked to see completed accident reports for people who used the service. The registered manager confirmed they were not following the organisation's accident and incident reporting procedure. We spoke with the registered manager about the importance of documenting all accidents and incidents so lessons could be learned, and care could be adapted to minimise the risk of further accidents re-occurring. They provided us with assurance that improvements would be made.

Systems and processes to safeguard people from the risk of abuse

- The registered provider had a system for responding and reporting abuse. However, we could not be assured systems and processes to safeguard people from the risk of abuse were consistently applied.
- We asked to see evidence that all reported concerns were taken seriously and investigated but no information was provided. We could not be assured therefore that reported concerns of abuse were thoroughly investigated and acted upon.
- Staff told us they had received safeguarding training and were aware of the importance of reporting abuse and harassment.
- People told us they had not been subject to any abuse or harassment. One person said, "I trust them to do right by me. They wouldn't hurt me or do anything they shouldn't."
- One relative confirmed care staff had followed procedures and raised concerns with the registered manager when their family member's care was not provided to the acceptable standard.

Staffing and recruitment.

- People were supported by staff who knew them well. We reviewed staff rotas and saw people were supported by a consistent staff team.
- Staff who worked within the domiciliary service told us they were happy with how their rotas were planned. However, we spoke with staff who worked within the supported living services and two staff told us in their view, more staff were needed. We spoke to the registered manager about this who advised action was being taken to address staffing concerns within one of the homes.
- Staff told us safe recruitment processes were followed and suitable checks were made before they were able to commence work.

Preventing and controlling infection

- People confirmed staff wore personal protective equipment in line with good practice guidance.
- Staff confirmed they had access to personal protective equipment and had received some information regarding good practice for restricting the spread of Covid-19.

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.

This is the first inspection for this newly registered service. We have not reviewed the rating at this inspection. However, we found 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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager did not always understand their responsibilities and regulatory requirements. There was an inconsistent understanding around management of risk and safe management of medicines. Concerns we identified during the inspection had not been identified by the registered manager.
- Organisational policies and procedures were not consistently followed to keep people safe. During the inspection, we looked at how specific incidents had been managed and we could not be assured organisational policies and processes had been followed. For example, the registered provider had not followed their own medicines, accidents and incidents and safeguarding procedures.
- We were not provided with assurances that auditing systems within the service were implemented and effective. Audits which had taken place had failed to identify the concerns we found. We were not provided with evidence of senior management audits until after the draft report was sent to the registered provider.
- Documentation was not always complete, accurate and up to date. Care records were missing key points of information which were important to promote safe and effective care. We identified errors in ten of the eleven care records we reviewed. Not all records and documents were supplied to us as requested and documents were not always completed in a timely manner. We could not therefore be assured the service was safe and well-led and the duty of candour was consistently applied.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we received confirmation from the registered provider that an independent consultant would be supporting the organisation to make the required improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Continuous learning and improving care

- The registered manager failed to ensure they consistently promoted a person centred, high quality care service. Action had not always been taken in a timely manner to improve people's lives. Partnership working with other health and social care professionals was inconsistent and not always pro-active.
- We could not be assured the registered manager consistently understood and applied the principles of the Mental Capacity Act 2005, (MCA.) The MCA aims to empower people to make decisions. When people lack

capacity to make their own decisions, the act ensures decisions made by other people are lawful and in their best interests. This act had not been consistently followed by the registered provider.

- Continuous learning and a focus on improving care was inconsistent. We could not be fully assured lessons were being learned in order to improve care.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and staff told us they were able to have a say in their service. Feedback included, "We had a chat about what I wanted, and they have stuck to their word" and, "They ask if I am happy with everything."
- Regular communications had taken place with people to check their welfare during the covid-19 pandemic to ensure people's well-being.
- A staff member said, "We have team meetings, we are listened to and can contribute, [registered manager] comes to the house to do them."