Premier Care Limited

Premier Care Limited - Wigan

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Premier Care Limited - Wigan is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to younger and older adults with various needs including, people with learning disabilities, sensory impairments and dementia. At the time of this inspection 144 people using the service received personal care. Not everyone who used the service received personal care. The Care Quality Commission (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 did not always feel safe receiving support from the service. Relatives told us, "It is so stressful I am constantly on edge and constantly worried about [relatives]." Medicines were not always managed safely or administered accurately. Risks to people had not always been assessed and risk management plans were not always completed. Infection and prevention control measures were not robust.

Appropriate training was not provided to staff. Staff were providing care before they were assessed as competent to complete their job role. The feedback from people and relatives was that staff were poorly trained and often did not know how to support people with specific needs.

Electronic care monitoring reports showed staff were regularly late for visits and some visits were up to two hours late. People told us they were not informed when staff were running late.

People and relatives told us they did not receive continuity in care workers.

People were not treated with dignity and respect. People and relatives told us, "[Relative] hates them [staff] coming in because of how they are with [relative]," and, "I don't trust them, and we can't rely on them." People's right to privacy was not always respected.

We received negative feedback about how the service was led. People told us, "The communication is poor," and "I wouldn't recommend them to anybody." The management of staff rotas was poor. Rotas had back to back visits with no travel time between a lot of the visits. On call systems to support people and staff during out of office hours were poorly managed.

Some people informed us they were not confident in raising their concerns on the telephone. We have made a recommendation about the provider reviewing their processes in obtaining feedback from people.

Staff felt the registered manager was approachable. Recruitment checks were robust to ensure staff were suitable to work with vulnerable adults.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 June 2019) and there was a breach of a regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing and training. As a result, we undertook a focused inspection to review the key questions of safe, effective, caring and well-led only.

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

The overall rating for the service remains as requires improvement. This is based on the findings at this inspection. 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 Premier Care Limited – Wigan on our website at www.cqc.org.uk.

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 breaches in relation to safe care and treatment, staffing, dignity and respect, and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Premier Care Limited - Wigan

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 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, which 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
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 26/11/2020 and ended on 08/12/2020. We visited the office location on 26/11/2020 and 30/11/2020.

What we did before 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 into account that we did not ask for the PIR 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 18 people who used the service and 20 relatives about their experience of the care provided. We spoke with 13 members of staff including the, registered manager area manager, head of governance, care co-ordinators, senior care workers and care workers.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and care records.

Requires Improvement

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 deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management; Preventing and controlling infection

- Medicines were not always managed safely. One person who managed their own medicines had not consented to support with administering their medicines, however a medication administration record (MAR) was implemented and a care worker had administered their medicines on a visit. No medication risk assessment was in place. Relatives told us, "Wrong medication has been given to [relative], morning pills have been given at night and my [second relative's] pills have been given to [relative]."
- Medicines were not always administered accurately. One person's MAR and PRN protocol (guidelines for as and when required medicines) stated a specific medicine was to be administered twice daily 10-12 hours apart. Staff had not followed the MAR instructions or PRN guidelines on numerous days and the person had not received their medicine as prescribed. A relative told us, "My [relative] gets anxious and has [name of medicine], staff have been giving it to [relative] totally wrong and too often."
- Risks associated with people's care had not always been identified. One person was receiving short term support with their personal care whilst they were COVID-19 positive and no risk assessments were put in place. This person lived in the same household with another person (without COVID-19) also receiving support with their personal care from the same service, however, infection control risk assessments or risk management plans were not implemented.
- People told us risks to their safety were not always considered. One person told us, "I have had to tell them [staff] about coming in [my house] without personal protective equipment (PPE), I rang the office and told them, but they [staff] still don't come in with PPE on and when they do, they [staff] leave the PPE on the home carpet. We are both vulnerable and shielding." Another relative said, "They [staff] have no concern for [relative's] safety. When staff leave they leave [relative's] phone out of reach, move the bedside table and don't put it back, so [relative] panics [unable to mobilise independently]."
- Preventing and controlling the spread of infection was not robust. 26 staff members had not completed the COVID-19 training course. A relative told us, "The carer had no personal PPE on when they visited [relative] and they [staff] know [relative] has COVID-19, I saw the same carer 20 minutes later coming out of one of my neighbour's houses wearing no PPE." One person told us, "Some of them [staff] don't wear uniforms. I have to tell them [staff], they say they forgot."

Medicines were not always safely managed. The health and safety of people and associated risks had not been robustly assessed and managed. This placed people at increased 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.

● The registered manager acted on the concerns during the inspection. They sought medical advice for the person who had not received their medicines as prescribed, completed a risk management plan for another person and informed staff to complete the COVID-19 training.

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

● People told us they did not always feel safe receiving support from the service. Their comments included, "I don't feel safe at all, half of them [staff] are not capable of grasping what you are telling them [staff]," and "I do not feel a hundred percent safe." A relative added, "They [staff] don't provide adequate care at all, it is really bad what they [service] is providing. My [relative] has been left in terrible states, staff have not even filled their water up."

● Staff had received training in safeguarding adults and understood how to recognise signs of abuse. Staff knew how to report any concerns. Staff told us, "I would report concerns to the manage or social services."

● When something went wrong, lessons learnt had been documented and shared. For example, when a safeguarding referral had been made to the local authority because of a missed visit, the lessons learnt had been logged.

Staffing and recruitment

● Recruitment checks were robust and ensured staff were suitable to work with vulnerable adults. Staff had the necessary safety checks in place before starting work. The registered manager told us they had recently had a high turnover of staff and have had the need to use agency staff because of staff shortages during the COVID-19 pandemic.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Appropriate training was not provided to staff. During the COVID-19 pandemic the provider could not provide practical moving and handling training, therefore staff were assessed as competent in moving and handling by a spot check. The spot check form used was not robust in assessing staff competencies in moving and handling. Staff told us, "No one came out to observe the moving and handling, I just had one spot check and I had already finished the care when [observer] came in," and, "When I first started they gave me a service user who had [support need], but they didn't give me training about how to support them and the client had to show me. I had online training for the [support need] a year later."

● Medicine competency checks were not always completed. Eight staff members did not have a medicine competency assessment in place to assess them competent to administer medicines to people.

● People and their relatives told us staff were poorly trained and often did not know how to support people with specific needs. Their comments included, "They [staff] are just not trained to handle my [relative] or their specific needs. The [name of moving and handling technique] is the main problem, they [staff] are just not trained. Like yesterday the carer was not competent to lead an agency worker, it was a disaster," "[Relative's] hoist was left wet and one carer couldn't use the hoist and left [relative] hanging out of their wheelchair," and, "The new ones [staff] are not trained at all. Some of the staff are flabbergasted with what to do, I have to assist them. They [Staff] shout me to do this and that because they can't use the hoist and don't know what to do. They keep pulling the cables out, they have no idea how to use [name of hoist]."

Suitably qualified and competent staff were not deployed. This placed people at increased risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received an induction into the service when they first started working there and had regular supervisions. We received mixed feedback from staff about the induction process, some staff felt it was rushed and brief, whilst others felt it was enough.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Electronic care monitoring reports showed staff were regularly late for visits and some visits were up to two hours late. People's comments included, "They [staff] always run late, and don't let us know," and, "They are very late, an hour and half late the other day, but they don't let me know when they're running late." A relative added; "They [staff] are not on time and they don't let me know when they are late. They

[staff] came at 11:30pm last week and [relative's] call is at 9:00pm. It's botched up. They don't know what they're doing. I've had to do the care because they [staff] are so late. They [staff] are supposed to be giving me a rest. I still have not got an explanation why [relative] got a call so late at 11:30pm last weekend."
● People and relatives told us they did not receive continuity in care workers. Their comments included, "They [staff] are not the same, I can't remember any of their names, there are so many", "Too many different staff who don't like working" and, "There is such a big variation in care and carers." The registered manager told us the COVID-19 pandemic has affected their ability to provide continuity of care workers due to the recent high turnover of staff, however they are working on gaining some stability for people who use the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were involved in their care planning. People's needs were assessed by the local authority and the service developed care plans with this information and by talking to people about their care needs. Most people had holistic care plans which were person-centred. People told us, "Somebody came in and asked me [questions about care needs]."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

At our last inspection we recommended the provider reviews the depth of information recorded in capacity assessments. The provider had made improvements.
● Decision specific capacity assessments were in place. Staff described their understanding of MCA and were able to identify their responsibilities to comply with the legislation. Staff told us, "MCA looks at whether somebody can retain enough information to understand what is being said and make a decision."

Supporting people to eat and drink enough to maintain a balanced diet
● Some people independently managed their food and nutrition or had support from their relatives. Where people required support with their food and nutrition, the level of support was agreed and documented in their care plan. Communication notes documented what foods were provided to people on a day to day basis.

Requires Improvement

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. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; Respecting equality and diversity

- People were not treated with dignity and respect. People told us, "The carer is not nice to me and makes me feel like I am something stuck to the bottom of their shoe," and "They [staff] don't always act professionally or treat me with respect. Relatives added, "They [staff] are not kind or caring, apart from one. Staff attitudes are poor, and they [staff] use foul language all the time whilst in the property," and, "All I want is for my [relative] to be happy, safe and treated with dignity, this is not happening."
- People's right to privacy was not always respected. People told us, "They [staff] just leave you exposed. If I was caring for someone, I will use towels or sheets to cover them up, they [staff] don't." Relatives commented, "They [staff] were undressing [relative] in the bedroom and walking [relative] naked through the hall into the bathroom, there is no dignity or dignified care at all," and, "[Relative] was put on the commode in front of [relative's] friends and [relative] was mortified."

People's right to privacy and dignity was not always respected. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff promoted people to live independently. People told us, "I try to do things for myself," and "Yes staff support with my independence by letting me wash my front." Staff gave example of how they promote independent living, their comments included, "When giving somebody a wash, I pass the flannel and let them wash what they can."

Supporting people to express their views and be involved in making decisions about their care

- Most people's views and decisions about care were incorporated within their care plans. The service had introduced the use of one-page profiles which included detailed information about people's history and interests.
- We received mixed feedback about how staff supported people to make day to day decisions. Comments from people and relatives included, "They [staff] ask me what I want," and "They [staff] don't give choices, they [staff] just do it [the task]."

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.

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

At our last inspection the provider had failed to ensure effective monitoring of the service to ensure people's care plans were reviewed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

● Governance systems did not provide effective oversight of the service to ensure people's care plans were reviewed and their care records were kept up to date. One person who started with the service in May 2017 had no record of reviews. People received a service user guide that informed them, 'Care staff can only carry out whatever duties are within your care plan.' One person's care plan did not reflect the support they were receiving.
● The management of staff rotas was poor. Rotas had back to back visits with no travel time between a lot of the visits. Staff informed us, "Rotas are dreadful. I was doing 16 to 18 hours on foot with no breaks on weekends. When I told the managers or co-ordinators, they kept saying they would sort it but did not. It is a nightmare and weekends are worse." Another staff member said, "There is not at all enough travel time, especially when we are walking too, it's not fair. A lot of people raise this, but they [management] don't do anything about it. It makes us late for calls, it's ridiculous."
● On call systems to support people and staff during out of office hours was poorly managed. Staff told us, "On call is not good, you either get ignored or they don't answer the phone at all. It's not good, if anyone is in danger or in an emergency, I can't get hold of anybody," and, "I text them [on call staff], they don't answer the phone, you have to text and text. I rang them once in the morning by the time they replied it was bed time and I didn't need them. On call are pointless. Family are more helpful than on call to be honest." A relative added, "I had to call out of hours as [relative] had a fall and couldn't get up, I tried 15 times, and no one ever got back to me."

Systems were not operated effectively and the provider had failed to maintain accurate and complete records. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded during the inspection and arranged the care plan review. They also informed us they had recently changed the on-call systems to have office based staff over seven days a week to eradicate some of the concerns. We will follow this up at our next inspection.

● A range of auditing processes were in place, however, the action taken post findings was not always clear. For example, during care plan reviews the provider's review form also audited the file and had a section dedicated to monitoring the service through seeking feedback. It was not always clear what action had been taken when a discrepancy was found or when a person made a complaint.
● Staff felt the registered manager was approachable. Their comments included, "[Registered manager] is approachable" and, " [Registered manager] is lovely and approachable."

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; Working in partnership with others
● The registered manager understood their responsibilities under the duty of candour, however, robust processes were not in place to inform people when staff were late for visits. We also identified one instance where the provider did not submit a statutory notification to the CQC. This is being reviewed outside of the inspection process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received negative feedback about how the service was led. Staff told us, "I will be leaving work, I don't like the company. Management in the company don't know what they are doing," and, "It [the service] is not managed properly." People and relatives told us, "I definitely wouldn't recommend them to anybody. [Registered manager] wants to get it right, but it's not right", "So badly organised" and, "I wouldn't recommend them, they are rubbish."
● We saw people's views had been sought through surveys conducted by an independent agency via telephone. Some people informed us they were not confident in raising their concerns on the telephone and would have preferred to fill out a form.

We recommend the provider reviews their processes in obtaining feedback from people.
● Staff received regular team meetings prior to the COVID-19 pandemic. Due to COVID-19 restrictions care worker meetings had been suspended and management kept in contact with staff via telecommunication.

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 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy and dignity was not respected.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed. The health and safety of people and associated risks had not been robustly assessed and managed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively and the provider had failed to maintain accurate and complete records.