Manchester Prime Care Limited

# Manchester Prime Care Ltd

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Manchester Prime Care is a domiciliary care agency providing personal care for people living in their own homes. The service was supporting six people at the time of our inspection.

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
Not all risks to people, or the measures needed to manage the risks, had been identified. Risk assessments in place had not been reviewed. The new manager was in the process of arranging reviews for people. Systems were in place where the service supported people to manage their money, although the recording of financial transactions could be improved further.

There had been a further change in owner and manager since the last inspection. Whilst improvements had been made in staff recruitment, training and support, further improvements were needed to provide oversight of the service and drive the changes needed to meet all regulations.

People and professionals were very complimentary about the staff and the support provided. The care staff were positive about working for Manchester Prime Care and the support they had from the manager and deputy manager. Care staff knew people's needs and how to prompt and encourage them.

Staff were safely recruited and had the training required to meet people's specific needs. The support people needed with their medicines was identified in their care plans. Staff had the required personal protective equipment and had receiving training in it's use.

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 13 November 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. Ownership of the service changed for the second time in August 2021, however the legal entity remains the same. At this inspection we found the provider remained in breach of regulations.
The service remains rated requires improvement. This service has been rated inadequate or requires improvement for the last three consecutive inspections.

This service has been in Special Measures since 28 July 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or

in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook an announced focused inspection on 28 September 2020 and three breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance, staffing and fit and proper persons employed.

We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met, to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the comprehensive inspection in March 2020 to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manchester Prime Care 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 monitor the service and will take further action if needed.

We have identified breaches in relation to assessing, managing and reviewing risks people may face and the quality assurance system not being robust 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 from the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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 well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-Led findings below.

# Manchester Prime Care Ltd

**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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by one inspector.

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 new manager who had applied to be registered with the Care Quality Commission. This means that they and the provider will be 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. Inspection activity started on 10 March 2022 and ended on 15 March 2022. We visited the location's office 10 March 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We had completed a Direct Monitoring Activity (DMA) call with the manager and provider on 28 February 2022. The DMA call looks for evidence that providers are meeting certain key areas including safety, staffing medicines and good governance.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During the inspection-
We spoke with the manager and nominated individual, who is also the owner fo Manchester Prime Care. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed two people's care records and two staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including quality assurance were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three members of staff, including care staff and the deputy manager. We also spoke with two people using the service and two professionals who have worked with Manchester Prime Care.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had not ensured staff had received the training they required to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- Staff had received the training required to meet the needs of the people currently supported by Manchester Prime Care. This included alcohol awareness and medicines administration. The new manager was introducing a more robust induction training and on-line refresher courses were also being completed by the staff team.
- Risks to people had not always been identified. Clear guidance was also not always in place to manage risks that had been identified'. For example, there was no environmental risk assessment for one person's home and one person was at risk of taking too much medication after drinking alcohol but no measures to manage this risk had been identified.
- Some risks people may face had been identified and guidance was in place for staff to follow. However, these had not been reviewed to ensure they were still current. The manager was organising reviews of people's support plan with the person and relevant professionals.
- Professionals we spoke with said the service communicated well with them about any concerns they may have about people's safety. For example, the service had arranged with the local authority social worker to assess one person's capacity to look at using technology to support them to remain safe when going out.
- However, under the previous manager, actions had not always been taken following an incident to reduce the risk of the same thing reoccurring. For example, one person had fallen asleep whilst smoking but no risk assessment was in place to identify measures to reduce the risk of a fire.
- The staff we spoke with knew people, their support needs and how to manage potential risks well. The manager was introducing a new care plan document which prompted an assessment of various risks, including the environment, moving and handling, financial management and medicines.

We found no evidence that people had been harmed. However, the failure to robustly assess the risks relating to the health, safety and welfare of people was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to implement robust recruitment procedures. This was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Staff files for current employees had been reviewed and all pre-employment checks were now in place.
● The manager had introduced a new recruitment pack which identified all checks required before a new member of staff was able to start work for Manchester Prime Care.
● People told us staff were on time for the support calls and completed all agreed tasks. Staff told us they had enough time to travel between calls. One person said, "The staff are great; they're very helpful and do what needs doing."

Systems and processes to safeguard people from the risk of abuse
● Manchester Prime Care supported some people to manage their finances and purchased items on their behalf. The local authority client finances department managed people's finances and were able to monitor all spending. Receipts were kept, it was planned to record all expenditure on a spreadsheet to enable the local authority to check the receipts with the person's bank statements, although this was not yet being done. One social worker said, "I have no concerns at all about how they handle [Name's] money."
● Staff were able to explain what they would need to report if they had any concerns or issues. The manager and deputy manager discussed any incidents and concerns during their weekly office meeting to ensure all appropriate actions had been taken.
● We were aware of a safeguarding that was currently being investigated relating to charges for the support provided by Manchester Prime Care under the previous registered manager. This was ongoing at the time of our inspection. The provider now had view of all invoices issued to ensure they were correct.

Using medicines safely
● The support each person needed to take their medicines was clearly recorded in their care plans. Staff described how they prompted and encouraged people to take their medicines and watched them as they did so. Staff recorded this on the electronic planning system and in the daily notes.
● Staff had completed on-line medicines training and assessments.

Preventing and controlling infection
● Care staff were provided with sufficient Personal Protective Equipment (PPE) and followed the current government guidelines during the COVID-19 pandemic. They had received training in PPE, including donning and doffing.
● Care plans identified where staff needed to support people with cleaning tasks to maintain people's environments.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. 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.

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

- Since the last inspection there had been a further change of ownership, management arrangements and the nominated individual had left. This showed the leadership at the service continued to be inconsistent.
- Due to the organisational changes, not all necessary improvements identified at the last inspection in September 2020 had been made. An experienced manager had recently been employed. The provider acknowledged they had areas of learning to clearly demonstrate their knowledge and understanding of the regulations and how these were to be met. A good governance tool was due to be introduced so the provider would have an oversight of the service.
- Some improvements had been made since the last inspection in staff recruitment, support and training. The new manager had completed spot checks, supervision, appraisal and staff meetings with all care staff. Reviews of people's needs were being arranged at the time of our inspection. A new care and risk assessment document was due to be used for these reviews. A weekly office meeting with the deputy manager had been implemented to ensure any incidents or issues had been reviewed and actioned.
- A new policy and procedure system had been purchased, which the care staff had access to through their mobile phones. A new electronic roster system had also been purchased and was being introduced. Staff would be able to access details of the care and support required at each support visit through their mobile phones.
- The initial changes made by the new manager were positive, but further improvements were needed to ensure all changes were embedded at Manchester Prime Care and all regulations were being met.

We found no evidence that people had been harmed and some improvements had been made since our last inspection. However, further work was needed to ensure robust quality assurance systems were fully implemented by the manager and the provider had sufficient oversight of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The feedback we received from people using the service was positive. They said the staff were respectful and completed all the tasks agreed in the care plans. People had been asked for their feedback on their support during the recent staff spot check visits.

● Feedback from members of staff was equally positive. They said they were supported by the new manager and the deputy manager, with more training being identified to develop their skills. Staff knew people's needs well and spoke positively about the people they supported.
● The professionals were also positive about the support provided by Manchester Prime Care. They said the staff knew the people they supported well. One told us, "For someone like [Name], who doesn't engage as a rule, the support is all done on his terms. The staff work with him closely so they are able to give more support than many other agencies would be able to do."
● The professionals we spoke with both said people had been supported to reduce their dependence on alcohol. One said, "They've got it (alcohol consumption) right down as far as they can. They've done a good job."

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 manager understood what needed to be notified to the Care Quality Commission.
● A complaints policy was in place.

Working in partnership with others
● The service continued to work with relevant health and social care professionals involved in the care and support of people who used the service. The professionals said there was good communication with the service.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There was a failure to robustly assess the risks relating to the health, safety and welfare of people using the service. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Further work was needed to ensure robust quality assurance systems were fully implemented by the manager and the provider had sufficient oversight of the service. |