Prime4 Care Ltd

Prime 4 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
Prime 4 Care provides personal care for people living in their own homes. At the time of our inspection visit eight people were receiving personal care.

People's experience of using this service and what we found
Risk assessments and care plans for known health conditions including epilepsy were not always in place. One person supported to take their medication had no medicine administration records. Some gaps in medicine records had not been identified because there was no formal system to audit records. Daily records did not always evidence when action was taken in response to health concerns.

Systems to ensure a consistent and thorough approach to risk assessment, monitoring and review were not effective. Staff spoke positively about their training and told us they were observed in practice. However, there were no records available to evidence the training staff had undertaken or observations of their practice. There was no system to review risk assessments after medical intervention. Improvements were needed to ensure a suitable recruitment system operated to obtain authentic references.

People told us they felt safe and well looked after by the care staff. Staff had knowledge of the risks to people's health and could describe how they would spot signs of infection linked to catheters and deterioration in people's skin. People were supported by staff who understood their responsibilities to safeguard people from abuse and harm. There were enough staff to meet people's needs safely by a consistent staff team. The provider maintained regular contact with people through weekly telephone calls to gather feedback, and whether there were any concerns or complaints. Staff wore Personal Protective Equipment (PPE) and carried out regular lateral flow testing.

People and their relatives gave positive feedback about their experiences of care and staff gave positive feedback about working for Prime 4 Care Ltd. The provider used regular telephone conversations and face to face discussions to gather feedback on people's experiences of care and whether any changes needed to be made. The provider was committed to improving the quality and safety of care for people, and was open and accepting of feedback from our inspection. There was a complaints process but no active complaints or concerns at the time of our inspection. The provider worked closely with the local G.P surgery and other health professionals including district nurses, to improve outcomes for people's care and health.

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

Rating at the last inspection and update
The last rating for this service was requires improvement (published 25 July 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements were still needed and the service remained in breach of the regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We carried out an announced comprehensive inspection of this service on 27 June 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the key question Well Led.

We undertook this focused inspection 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 last inspection to calculate the overall rating. The overall rating for the service remains 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 Prime 4 Care Ltd 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 Regulation 17 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 from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider to monitor progress and 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.

Prime 4 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 Care Act 2014.

Inspection team
The inspection team consisted of 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.

Registered manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection the service had a registered manager in post, ut they were unavailable at the time of the inspection.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 28 April 2022 and ended on 13 May 2022. We visited the office location on 3 May 2022.

What we did before the inspection
We reviewed information we had received since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. We used all this information to help plan our inspection.

During the inspection
We spoke with three relatives and two people about their experiences of care and six members of staff including the provider and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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. The rating for this key question 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

● At the last inspection, risk assessments did not always contain information related to known health conditions such as epilepsy, to ensure a consistent response in the event of a seizure.

● At this inspection whilst some improvements were made, we found repeated issues with risk assessments and care plans.

● Staff told us one person with epilepsy had an average of one seizure a year. However, care records documented them having two seizures very close together during a care call. It was unclear, in the records, whether staff had sought medical advice and the provider told us there was no epilepsy care plan. We were not assured there was enough information to ensure staff could safely manage the risks of epilepsy.

● One person was supported by district nurses for the treatment of leg ulcers and the provider spoke with district nurses when staff reported any concerns, or when the district nurses missed a visit. However, there was no risk assessment or care plan for this condition and the provider did not know the severity of the skin damage. We provided feedback on this issue and the provider took action to rectify the shortfalls.

● Staff had knowledge of aspects of safe care for some specific conditions. For example, staff could explain the actions to clean and check a catheter. They also knew when to report concerns. One staff member said, "I make sure I moisturise their skin after personal care. I've not come across [problems with skin] but if I see any spots, dry skin, redness or bleeding I would report it."

The provider responded during and immediately after the inspection in response to the issues identified. They implemented new care plans and risk assessments for specific health concerns.

Staffing and recruitment

● At the last inspection improvements were needed to recruitment processes. At this inspection there were some improvements and records of Disclosure and Barring Service (DBS) checks were now in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, further improvements were needed to reference checks.

● There was no system to ensure references provided by previous employers were authentic. The provider assured us a new system would be implemented.

●There were enough staff to meet people's needs safely by a consistent staff team, and staff were allocated sufficient travel time between care calls. One relative said, "[Person] gets continuity with staff, they know her likes and dislikes." Another person said, "My needs are limited, they know how to look after me. When they introduce a new person, they are inducted and come in with someone else so they can monitor what the other person is doing."

● Staff told us management were responsive to their feedback when people needed more time, and would change the length of care calls accordingly.

Using medicines safely

● The provider told us staff received medicine competency training before being allowed to support people with their medicines. However, there were no records of training or details of observations of staff practice.

● Systems did not identify gaps in some medicine administration records and there were no records to ensure patch medicines were applied according to manufacturer guidelines. This is important because patch medicines can cause skin irritation and affect how the body absorbs the medicine if it is not applied to the body according to a specific rotation.

● One person needed support with epilepsy medicine because of short term memory loss. However, due to a lack of understanding there was no medicine administration record for this person. The provider assured us this would be rectified immediately.

● People who received support with their medicines reported no concerns or complaints and were satisfied with the care they received. There was no evidence that this impacted on the care people received.

Systems and processes to safeguard people from the risk of abuse

● People were supported by staff who understood their responsibilities to safeguard people from abuse and harm. Staff understood what to look for and do if they suspected abuse. Staff told us who they would contact and felt confident their concerns would be acted upon.

● Contact details for the safeguarding authority were available for staff in the office, but not all staff knew where to access this information or who to contact externally.

Preventing and controlling infection

● Staff were provided with Personal Protective Equipment (PPE) to help prevent and control infection.

● Regular lateral flow tests for asymptomatic testing were carried out by staff.

Learning lessons when things go wrong

● The provider maintained regular contact with people through weekly telephone calls to gather feedback, and whether there were any concerns or complaints. In response to feedback from one person, changes were made to the care staff who supported them. One person requested a copy of the rota so they knew who would be coming to support them. This request was implemented.

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 requires improvement. At this inspection the rating has remained 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider failed to ensure systems were always in place to keep people safe. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems to ensure a consistent and thorough approach to risk assessment, monitoring and review were not effective.
- Risk assessments and care plans for known health conditions were not routinely in place or clear and accurate. One person with epilepsy had no risk assessment or care plan for their condition until after they had experienced seizures. There was no system to review the risk assessments after medical intervention.
- Another person was identified as having epilepsy, diabetes and a history of falls. There were no risk assessments or care plans for these health conditions. The provider informed us that due to health improvements, this person no longer had diabetes. Their assessment had not been updated to reflect this.
- Systems to monitor medicine administration did not identify gaps in records or issues related to guidance for the safe application of patch medicines.
- Staff spoke positively about their training and told us they were observed in practice. However, there were no records available to evidence the training staff had undertaken or observations of their practice.
- Care records did not always evidence when action was taken in response to health concerns or incidents or when conversations took place with other health professionals regarding people's care.
- At our last inspection, recruitment processes and records required improvement. At this inspection improvements were needed to ensure a suitable system operated to obtain authentic references.

Systems to continually assess, monitor and mitigate risks to the health, safety and welfare of people and assess, monitor and improve the quality and safety of people's care were ineffective. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and immediately after the inspection in response to the issues identified. They submitted an action plan and implemented new care plans and risk assessments for specific health

concerns.

● Staff could describe some risks related to health conditions and people and their relatives spoke positively about care staff knowledge and competency. One person said, "I have a catheter that needs changing and I've never had any concerns with how they manage it."

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

● People and their relatives gave positive feedback about their experiences of care. One relative said, "I've got nothing but praise. I live in the South and they keep me informed of everything. If [person] needs anything, or something is wrong that means he might need to see a doctor. Anything that might need my approval or input." Another relative said, "They're wonderful with [person], I'm so happy with them. Really nice and really concerned about how they help her."

● Staff also gave positive feedback about working for Prime 4 Care Ltd. One staff member said, "To be honest, they're quite approachable. It's a small company. We get lots of reminders asking us if we need extra support or if we need anything – their door is always open." Another said, "They're good, I've no complaints with them. They've been supporting me when I need support, they listen as well. If you give them ideas, they look into it."

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

● The provider used regular telephone conversations and face to face discussions to gather feedback on people's experiences of care and whether any changes needed to be made. One person said, "[provider] comes to see me from time to time, so I'm not just a client on a list who's assessed at first and never seen again. When it's a discussion over the phone, or indeed face to face, it's about particular members of staff who've started working with [Prime 4 Care Ltd] asking about the standard of care and whether I feel safe."

● Staff were given the opportunity, during supervision, to share their views on the service and what could be improved.

● There was no system to record people's feedback on care or the changes implemented in response. The provider recognised records needed improvement and agreed to implement a new system to record when feedback was gathered either through telephone calls, or care reviews.

Continuous learning and improving care

● The provider was committed to improving the quality and safety of care for people, and was open and accepting of feedback from our inspection. Action was taken during and after our inspection to start addressing shortfalls in the service.

● The provider linked in with a local domiciliary care service for advice and guidance when implementing changes to the service.

● There was a complaints process available to people and information on how to use this was provided in an induction pack. There were no active complaints or concerns at the time of our inspection.

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 had an understanding of the types of incidents and important events to be reported to the CQC.

●They told us that they would share any concerns or incidents directly with staff and would be open and honest with people when something goes wrong.

Working in partnership with others

● The provider worked closely with the local G.P surgery and other health professionals including district nurses, to improve outcomes for people's care and health.

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 17 HSCA RA Regulations 2014 Good governance Systems to continually assess, monitor and mitigate risks to the health, safety and welfare of people and assess, monitor and improve the quality and safety of people's care were ineffective. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.