Premier Nursing Agency Limited

Premier Community

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Premier Community is a domiciliary care agency providing personal care to people in their own homes. They support older adults with a range of physical and mental health needs. At the time of our inspection there were 393 people using the service.

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.

The service is split into 3 areas, each individually managed. The areas are Nottinghamshire, Derbyshire North West and Derbyshire North East.

People's experience of using this service and what we found
Feedback we received for Derbyshire North West and Nottinghamshire raised several concerns. However, feedback about Derbyshire North East was more positive.

People did not always receive their calls at their preferred or even scheduled times. Calls were often condensed or cut due to staffing demands and people's needs were not always all met as a result.

People did not always receive care in a person-centred way and care plans were not always being kept up to date to reflect people's current needs and requirements.

People were supported to take their medicines although not always in a timely way and recording was not always in line with best practice.

We have made a recommendation around medicines management.

People experienced a lack of communication from management. Staff also felt they were not being supported. The provider did have systems and processes in place to monitor the quality and care delivery of the service, however these had not proved effective in improving the service. The provider was aware of some of the concerns and had taken measures to ensure people's experiences improved.

People told us the carers were kind and treated them well. People felt safe whilst being supported by them and staff knew how to protect people from risks and abuse.

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 31 May 2019).

Why we inspected
We received concerns in relation to call timings, missed calls and a lack of response to raise concerns. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

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 has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

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 Community on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 staffing, delivering personalised care and governance. We also made a recommendation about medicines management and documentation.

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 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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive 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 Community

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
This inspection was carried out by an inspector and 3 Expert's 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were 3 registered managers in post.

Notice of inspection
We gave the service 24 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 21 October 2022 and ended on 10 November 2022. We visited the location's office 2 November 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 40 people who used the service and their relatives. We spoke with and sought feedback from 40 members of staff, including the 3 registered managers, care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from 2 healthcare professionals who worked with the service. We reviewed records relating to people's care, staff training and governance of the service.

Requires Improvement

Is the service safe?

Our findings

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 good. At this inspection the rating has changed 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.

Staffing and recruitment
● People experienced inconsistent support in terms of the timings of visits and the durations of these calls, we saw evidence of this in call records.
● People, and their relatives, said in relation to calls, "The planning is atrocious," "Timing is an issue. Sometimes calls are moved and reduced. There are not enough carers. There are constant changes of timings," and "The carers are never on time, they can be late or early. I've had numerous meetings with the agency about it. They say they can't do anything about it as they are understaffed."
● Staff described their distress at being unable to meet people's needs on every call due to calls being cut short by the provider. Staff said they were given very little travel time, and records corroborated this, which meant they were often running late. Staff reported they were given too many calls to complete in a day and sometimes they were sent on a call alone when the person required 2 people to support them.
● Staff said, "We feel the service users are getting let down, we hear it at every call we go to, times are being moved, 7 one morning and 10 the next day and calls are cut down," and "We only get five minutes to travel between calls and traffic is never factored in. This makes us late."
● Staff described having to work long hours, which they feared could lead to unsafe care delivery.
● Despite the provider having a set process for induction, some staff raised concerns about new staff not always being given enough practical training and to learn people's individual needs. A newer member of staff told us, "Without in-person training I felt somewhat unprepared when I first started."

The provider had failed to ensure they had enough suitably trained staff to deliver care as planned. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified issues and was taking measures to improve staffing, this included changes in recruiting processes, restructuring and instating a quality lead. We found no evidence of anyone coming to harm as a direct result of these staffing concerns.

● Staff had been recruited safely. There were robust pre-employment checks in place, these included checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People were supported with their medicines, although due to staffing issues mentioned above, they were

not always supported in a timely manner and some medicines were not given as prescribed.
● People told us and records we reviewed confirmed, people who were prescribed medicines which were time specific or required a set amount of time between doses were not always supported to take these as prescribed. A relative said, "Sometimes they can be an hour late, so it upsets their medication."
● Records we checked contained out of date information regarding people's medicines.
● Staff were not guided by the provider to record all types of medicine support; therefore, it was not being recorded when people had been prompted to take medicines or when staff helped people remove medicines from their packaging.

We recommend the provider considers current guidance to ensure medicine administration, recording and policy is in line with best practice and take action to update their practice accordingly.

Assessing risk, safety monitoring and management
● Risks associated with care delivery, environment and people's individual needs and conditions had been considered.
● Where people needed staff to support them with specific high risk needs, these had been assessed and documented. For example, where someone had a catheter in-situ risk assessments were in place to guide staff on how to monitor for the risk of infection.
● Contingency plan assessments were in place to ensure people's safety was the priority when having to reduce call times or cancel calls. However, we did find some instances in call log records where these were not always able to be followed due to the above staffing issues. Staff said, "We have an hour call for someone who has Parkinson's, they had their call cut to 35mins, they [the provider] need to put it back to an hour. [The provider] are just not communicating to us, they aren't asking us who to cut and are not assessing people before they cut times."
● Overall risks were managed well, however due to staffing pressures the provider was not always able to reassess people's needs in a timely way to ensure they were not placing them at increased risk when cutting calls.

Learning lessons when things go wrong
● Senior management were able to give examples of where they had learnt lessons and made changes to mitigate risk or improve the service. However, staff told us they were not made aware of outcomes from concerns they had raised; therefore, we cannot be confident lessons were shared amongst the staff team.

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded by the processes and systems in place.
● Staff were trained on and knew how to recognise potential signs of abuse or neglect and understood how to escalate these appropriately.
● Staff said, "I can honestly say that I feel that every member of Premier Care takes safeguarding our service users seriously."

Preventing and controlling infection
● Infection control measures were highlighted throughout care plans and staff were prompted to wear appropriate personal protective equipment (PPE).
● People told us care staff wore PPE when they supported them with personal care.
● The provider understood current guidance in relation to PPE levels and testing for COVID-19.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not always receive person centred care.
- People and staff told us, and records showed, people were not always getting their preferred times of calls.
- Due to calls being condensed, this meant staff were unable to meet people's wider needs beyond providing basic personal care and sometimes those basic needs were not being met. For example, a relative told us, "[Staff member] didn't even want to do any kind of personal care and they didn't empty the commode, they didn't want to be there, didn't stay the right amount of time and told my [relative] that they didn't have time and had to go."
- Another said, "[The provider] have cut her calls from 45 minutes to 30. They can't possible do everything they need to do in the mornings in 30 minutes. A person told us, "Visits are random, no consistency. They don't do what they're supposed to do."
- People were confused when they were asked for their calls to be cancelled, a person told us, "The office called me last Sunday to see if I could manage without a call that day, I didn't understand, the point is I need help."
- Some people told us they had not seen their care plan and had not been involved in developing it or had any reviews of their care.
- Care records were not always kept up to date to reflect people's current choices and requirements. Staff explained, "I've sent concern reports in regarding changes that need to be amended on individual's care plans which don't get actioned or take a long time to be actioned."
- The provider had an 'end of life' policy in place which was well written, but in the records, we checked we found no evidence of the advised care planning around end of life having been put into practice.

The provider failed to ensure care was planned and delivered in a personalised way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other people had a more positive experience. For example, "I have recommended this service to other family members as I feel they do give good care. There is a care plan and I was involved in the decisions along with my [relative] and there are 6 monthly reviews."

Improving care quality in response to complaints or concerns

- There had been a new system and process implemented to ensure people's concerns were responded to. However, some people told us this had not always been the case and there was little evidence of improvements following concerns being raised.

● People told us, "If I try to ring the office I can't get to speak to the manager and if I email the office I get no reply" and "I have complained about timings of visits – they are never on time – but nothing improves."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's care plans contained minimal information about their communication needs.
● The provider was able to share information in a way people would be able to access if required.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The service was divided into 3 areas, each individually managed by a different registered manager. The concerns described in this report predominantly affected the Nottinghamshire and Derbyshire North West areas. Feedback from staff and people in the Derbyshire North East area was generally positive.
- Staff told us they did not have regular supervisions and there were inconsistencies in the support they received from management. Both staff and people stated management ignored their emails and attempts to get in contact with them when they tried to raise any concerns.
- Staff felt meetings were not productive and often felt like they were just there to be told off or attacked by management.
- People told us they did not always feel engaged or included, care was not always being delivered in a person-centred way, they experienced inconsistencies in care delivery and communication was poor. For example, a person told us, "We have no contact from the office, I phoned them once and they never called me back, so I don't bother now." Another person said, "There is now a definite lack of leadership and vision."

- The provider did have quality assurance and monitoring systems and processes in place; however, these were not being utilised effectively in order to pick up the issues we identified during the inspection. For example inconsistencies in care planning and recording medicine support.
- Where people had received care plan reviews, issues identified as part of these were not being addressed. For example, one review stated, "evening call not suitable", but this review was signed off by management as, "good review -no changes to be made".

The provider failed to ensure they had effective quality monitoring measures in place, failed to act on feedback received and failed to ensure they kept complete and contemporaneous records. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified there were issues within management, governance and quality monitoring processes. They described how they had plans to make improvements, this included creating new roles in quality management and restructuring the service.

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 managers understood their legal responsibilities, including submitting statutory notifications to CQC, informing the local authority of safeguarding concerns and being open with people.
- People told us where things had gone seriously wrong, they had received apologies from management.

Working in partnership with others

- We saw evidence of the provider working collaboratively with other health and social care professionals.
- Feedback from professionals was positive, one said, "I find generally they do respond appropriately and in a timely fashion and do try to be helpful."
- The service had developed positive links with the wider community and the registered manager told us how each area of the service has a charity they support. These included food banks and hospices.

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 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The provider failed to ensure care was planned and delivered in a personalised way. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider failed to ensure they had effective quality monitoring measures in place, failed to act on feedback received and failed to ensure they kept complete and contemporaneous records. Regulation 17 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure they had enough suitably trained staff to carry out calls as planned. Regulation 18 (1)