Premium Community Care Ltd

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

Summary of findings

Overall summary

The inspection took place on 6 June 2016 and was announced. The service is a domiciliary care service and provides care and support to 51 people in their own homes.

The service was last inspected in April 2014. There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not consistently safe. There were no assessments and monitoring systems in place to support people with the specific risks related to their healthcare conditions. People were not always protected by robust recruitment processes.

People did not always receive their support calls on time and this was an ongoing concern that had been raised by some people and relatives. Processes were not robust to assure that people always received their medicines safely. The registered manager and staff had taken action to keep people who used the service safe in response to concerns.

Staff told us that they felt supported in their roles and we saw that they received training and supervision. We saw that people were encouraged to make their own decisions and choices, however we saw that the staff did not always work within the principles of the Mental Capacity Act.

People told us that staff provided them with choices when helping them to prepare meals. However, we found that staff had not always monitored and identified if people with special dietary requirements had eaten and drank enough to remain well. People were encouraged to access healthcare support when necessary and relatives were informed during emergencies or if people became unwell.

People and relatives told us that staff were caring, however some feedback suggested that this was not consistent practice. People's daily care notes were written respectfully and people told us that they were supported to maintain their independence and dignity by staff.

People and relatives told us that they had been encouraged to share their feedback and views. People and relatives were involved in developing and reviewing care plans and they felt that these reflected people's needs. A professional told us that staff listened to people about their care needs.

The registered manager told us that they sought feedback from people who used the service through sending questionnaires, reviews and by keeping in touch with people.

While people told us that they felt able to complain if they had concerns about the service, the registered

manager did not always respond effectively to concerns that people and their relatives had raised.

People we spoke with told us they were happy with the service and the support that staff provided. Staff told us that they found the registered manager approachable and promoted a learning culture.

Processes to manage risks to people and monitor and improve the quality of the service were not always effective.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People did not receive the support they needed at agreed times which put some people at risk.

People were at risk of not receiving their medicines as prescribed and the associated risks of not having prescribed medicines were not consistently well managed.

The registered manager and staff knew how to report safeguarding concerns and had helped to keep people who used the service safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported with eating and drinking to remain well but at times this was not consistently managed as required.

People told us that they were supported to make their own decisions and exercise choice and independence.

Staff received training and ongoing support in their roles.

People were encouraged to access healthcare support when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us that staff were caring but often experienced care being provided later than planned.

People's feedback suggested that their needs were not always met.

People were supported to maintain their independence and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's complaints were not always addressed or responded to in line with stated expectations.

People and relatives were involved in developing and reviewing care plans.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not have effective systems in place to identify and address key issues affecting the quality of the service.

People and staff were encouraged to share feedback and found the registered manager approachable.

The registered manager supported staff who found them approachable.

Premium Community Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 June 2016 and was announced. The provider was given 48 hours' notice so we could ensure that care records and staff were available to help inform our inspection. The inspection was conducted by an inspector and an expert-by-experience, whose area of expertise was in mental health services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection. We also referred to information held by the local authority about the service.

During our inspection, we spoke with eight people who used the service and seven relatives. We spoke with five members of staff, the registered manager and one professional. We also reviewed four people's care records, six staff files and records maintained by the service about risk management, staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives had mixed views about timeliness of calls and identified that staff did not always arrive to calls on time. Some relatives told us that they were satisfied with staff arrival times and felt assured that staff would keep them informed if they were going to be late. One relative told us that although staff timekeeping had improved, there were still occasions where staff arrived up to 30 minutes late to calls. Another relative told us, "We don't expect carers to be on time because of emergencies but [they are late] all the time… when carers know they will be late, they could tell us this so that [their relative] can relax," and added that the person had not received their medicines when they needed it on occasions that staff were late. They also told us that when staff were late their relative had become concerned wondering whether staff were going to turn up or if they should prepare their food independently at meal times.

Another person's daily records highlighted that they became 'Anxious and concerned' due to the late arrival of staff to their call. This person required support from staff with their dietary intake and had experienced an accident trying to prepare a meal and drink when staff had failed to attend a call as planned. Records confirmed that people often experienced late calls and in one instance a person received their call one hour and 20 minutes late. Although people's care records had recently been reviewed and the registered manager was aware of people's concerns with staff call times, they had not taken action to ensure enough staff were available to support people in line with their care needs.

No review or action had been undertaken to identify if there were insufficient numbers of staff employed or if the deployment arrangements needed to be changed. Failure to ensure there are enough staff who are effectively deployed is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some relatives and people who used the service told us that they had no concerns in relation to how people were assisted with taking their medicines. One relative told us, "They give [person's name] the medication in the morning and it works fine." However, we identified that people were at risk of not receiving their prescribed medicines or not receiving their medicines in the correct dosage. Records of medicines administered were inconsistent with the records of prescribed medicines that were maintained in people's daily notes. There was not a robust system in place so that staff could clearly record which medicines people had taken or when this had been administered. Therefore it was not possible to identify whether staff had supported people to take their medicines as prescribed.

People's care plans did not always provide guidance to instruct staff how and when people should have taken their medicines or had their prescribed creams applied. The inconsistencies between records put people at risk of not receiving medication in line with the prescriber's instructions. Some people had been prescribed medicines to be taken 'as needed'. Care plans and administration records lacked guidance for staff as to why people sometimes required the medicine and in what circumstances staff should support people to take it. Although some notes indicated that a person using the service had taken their own medicines independently or with the help of a relative, records did not clearly outline details of where they

had refused their medicines. We saw on one person's records that there were no reasons provided as to why they had refused their medicines and although this had happened frequently, this had not been identified as an issue or investigated further. This person was at risk of not receiving the medicines they needed to stay well. Audits of the medicines records by the registered manager had been conducted regularly and although these identified some minor issues, we saw that the above issues had not been identified or effectively addressed through this process.

Failure to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe and one relative told us, "We've no concerns about any of the people coming in." People told us that they had a good relationship with staff and that they could contact the registered manager if they felt unsafe. Staff could identify different types of abuse which people were at risk of and knew how to report safeguarding concerns appropriately. The registered manager told us that there was a whistleblowing policy in place and we saw that they had responded appropriately when they had received information of concern.

There was no detailed guidance for staff about how they were to protect people from the risks associated with their health conditions. In one instance we saw that care records for a person who had been identified at high risk of harm due to a lifestyle choice did not contain detailed information for staff as to how they could manage this risk and keep the person safe. When people's health care needs changed, the registered manager had not always updated people's care records to ensure staff had correct information to support people safely. There were no guidelines for how staff were to support people who were at risk of developing sore skin and a review of people's daily notes showed that actions were not consistently taken to manage this risk. We saw however that the registered manager was taking action to introduce some common guidance for staff.

We found that incidents were not always used as a learning opportunity to improve how risks were managed. For example, despite records reflecting that there had been an identified concern relating to keeping a person's belongings safe, the registered manager had not taken action to prevent this from happening again. There had been an incident where faulty equipment had been identified as putting another person at risk of harm, the registered manager had not taken effective action to introduce a formal system to regularly assess the safety and servicing requirements of people's equipment. We also saw that incident records did not always provide details of action the registered manager had taken when people had been at risk of harm.

The registered manager had taken steps to reduce the risks associated with lone working and staff told us that they were able to access people's homes safely. Records showed that although there was an appropriate job application and interview process in place, pre-employment checks had not been always completed or recorded correctly for all staff members. Records we sampled showed that reference checks had not been undertaken suitably for two staff members. We found that another staff member recruited in 2014 had worked at the service for over eight months before the suitable checks were completed through the Disclosure and Barring Service. It was not possible to confirm whether this check had been completed in a timely way for one other staff member who had been recruited more recently as their start date had not been recorded. This meant that people were not always protected by robust recruitment processes.

Requires Improvement

Is the service effective?

Our findings

Most people and relatives said that staff knew how to fulfil their roles well and one relative told us, "They always do a good job." Staff we spoke with told us they felt supported in their roles and records showed that they received supervision. One staff member told us, "We have enough training, if we don't feel confident, they will go over it again and again with us until we get it." This staff member told us that they were guided on how to improve in their role by senior staff members and through performance observation reviews. Another staff member provided moving and handling training to other staff members and conducted performance observations to assess staff moving and handling knowledge. We saw that the performance observations also assessed whether staff treated people with dignity and respect and if they had sought their consent before providing support, although we saw that feedback notes sometimes featured generic phrasing.

Staff received training for their roles and we saw that they provided positive feedback about their training sessions in evaluation forms. Staff members we spoke with demonstrated an understanding of the needs of the people they supported. New members of staff completed shadowing and training early on in their role and were supported to complete the Care Certificate. The Care Certificate is a nationally recognised training programme that outlines the minimum care standards that new care staff must cover as part of their induction process. The registered manager told us and records confirmed that they shared guidance and social care resources with staff so that they could maintain their knowledge of the latest best practice.

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 and relatives we spoke with told us that people were supported to make their own choices and decisions. One person told us, "They recognise how independent I am," and another person told us, "I feel in control of how things work [in relation to their care]." The registered manager was able to tell us about the Mental Capacity Act and described a best interest decision meeting that had taken place for a person who used the service. However, although staff provided examples of how they encouraged people to make their own choices, they were not aware of the MCA. Feedback from one person who used the service suggested that they had sometimes felt ignored by staff and that staff did not always respect their choices and preferences. We did not see evidence that the registered manager had taken action to ensure the person was supported in line with their wishes.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that some people who used the service used bed rails, yet this information was not detailed in their care plans and there was no evidence that the registered manager had made enquiries to identify if the decision to use equipment had been agreed in line with best interests and the person's choice.

People told us that staff offered choices when they helped them with preparing meals and one person told us that they were always given enough to drink. Some people who used the service had special dietary requirements, however staff had not always recorded if they had supported people in line with their nutritional care plan and the identified need to maintain records. For example, one person's daily fluid and food monitoring notes were not consistently completed, with gaps in one person's daily records for up to 19 days on one occasion. Records showed that a relative had prompted staff to complete these records as required because the person using the service had appeared to lose weight. Feedback from another relative indicated that staff did not always maintain records of a person's weight as required and that they had not recorded information following their healthcare appointments. We saw that one person required support with maintaining healthy nutrition, however no guidance for staff or dietary monitoring records featured in their care plan. Although these records were reviewed through a regular auditing process, none of these issues were identified or addressed.

People told us that staff had supported them to access healthcare appointments or they felt confident that staff would support them if this was required. One person told us, "They did it once for me when I was unwell." We saw that staff encouraged people to see healthcare professionals when necessary, even if they were reluctant to do so initially, to ensure that people accessed appropriate care and treatment. Most records indicated that staff promptly consulted healthcare professionals and informed people's relatives in the case of emergencies or if people were feeling unwell and we saw that staff followed healthcare guidance.

Requires Improvement

Is the service caring?

Our findings

A person who used the service told us, "[Staff] are kind and caring." One relative told us, "They're great. We've got good carers," and another relative explained how staff had taken their relative into the garden recently and that this had meant a lot to them. The registered manager told us that there was a consistent staff group who knew people's preferences and had established a good rapport with people who used the service. One relative told us, "Some of [the carers] are almost friends, we have a laugh with them, we look forward to them coming, we have no problems with any of the staff."

We saw that daily care notes were written in a respectful style and tone and people and relatives told us that staff communicated with people in an appropriate way. Some care notes we reviewed referred to making the person feel comfortable, having a chat with them and leaving them safe in their home. One staff member's care notes showed that they 'Had a nice laugh,' with the person.

The issues with late calls had a negative impact on the experience of people using the service. Some relatives shared concerns about staff being unable to deliver care in a timely way as planned on a frequent basis and that people had become worried or distressed when their care call was later. One relative told us, "The carers are saying they have too many appointments, surely the registered manager knows [if staff will be late] and could tell us."

People told us that they had shared feedback through surveys, reviews and conversations with the registered manager. People we spoke with confirmed this and we saw an example in one person's care records where staff had offered a clear explanation and support to them. On one occasion however we noted the registered manager had not responded when a person raised concerns about a member of staff's behaviour and they had not respected this person's right to be heard or to receive a fair and open response.

The registered manager told us that they had distributed a feedback questionnaire to people who used the service last year in order to help them express their views about the service. We saw that the majority of responses were positive. The feedback indicated that people had felt staff were professional, respected their privacy and views and they were supported to feel comfortable and safe in their own homes. The registered manager told us that they had addressed the one instance in which a person raised a concern and that they had not distributed another survey this year as last year's survey had a low response rate. Although the registered manager felt that there had been a poor response to last year's survey, they had not yet analysed the questionnaires returned for trends and ways in which they could improve the service that people received.

Some people and relatives told us that staff helped people to maintain their independence. A person using the service told us, "They help me with the things I need help with, not with what I can do myself." Another person using the service said, "[Staff] are enablers, not bosses." One relative told us that staff encouraged their relative to do things that they wanted to do.

Relatives we spoke with told us that staff treated their relative with dignity and respect. A staff member told

us how they ensured that people had the privacy they needed and provided us with examples of how they maintained people's dignity. We noted that performance observations were conducted to ensure that staff continued to respect the people they supported. However, some feedback we reviewed indicated that people were not always treated with respect and dignity and that staff did not always demonstrate professionalism. For example, three people had complained that staff were not supporting them with their needs as required and a relative raised a similar concern on behalf of another person. We saw that the registered manager had taken some steps to address these concerns with staff.

Requires Improvement

Is the service responsive?

Our findings

A person who used the service told us, "[Staff] never leave before asking, 'Is there anything else you need?'" Relatives told us that staff provided care as people required. People and their relatives told us that people usually received care from regular carers who had got to know how they wanted to be supported. The registered manager told us that they tried to arrange for people to be supported by staff with whom they believed they would develop a positive rapport. The registered manager told us that some people who used the service had enjoyed participating in a jigsaw swapping club that a staff member had organised.

People and their relatives told us that care plans reflected people's needs and that they felt involved in the care planning process. A professional told us that people were involved in care plan reviews and that staff listened to people about their needs. A relative told us that staff visited their relative on a monthly basis to review their care plan and told us, "It's all written down and staff follow it." We saw that people's care plans provided limited details for staff about their interests and personal histories, however they did include a useful summary of their needs, which included key information about their medical histories, risks, conditions and ongoing support they required from healthcare professionals. Care plans also detailed the support that people wanted during their appointments with staff and the contact details of people's next of kin and healthcare professionals. People we spoke with confirmed that staff supported them in line with their expressed wishes and care plans.

People we spoke with told us that they would feel able to complain if they had concerns about the service provided and referred to the surveys and reviews in place for them to share their views. One person told us that they had complained and that they were satisfied with the response they had received, and a professional told us that the registered manager answered concerns promptly. People who used the service received a handbook which outlined the complaints process and we saw that there were some records of complaints and compliments that had been received. A recent compliment noted that staff 'Always went that extra mile and beyond their duties.'

We saw that no complaints had been recorded since 2013, however on our review of a separate folder containing quality feedback issues, we highlighted to the registered manager that some issues raised through this process were concerning. We found that the issues raised met the definition of a complaint as detailed in the service's own complaints procedure, but that they had not been addressed as such. For example, there was no record to indicate that the registered manager always reassured people that their concerns had been heard and addressed when they received concerns, for example about poor care and staff conduct. Systems did not ensure that complaints were handled in a consistent and fair manner. The registered manager advised us that the senior staff team had begun to develop action points to improve some of the issues that had been raised, for example staff timekeeping and ensuring that staff wore appropriate uniforms and communicated in a way that people could understand.

We also reviewed a staff member's statement which detailed an altercation during which they had spoken to the relative of a person who used the service inappropriately. We saw no evidence that this incident had been investigated. When we queried this with the registered manager, we found that they did not proactively

reflect upon or consider alternative responses that the staff member could have made. Although the registered manager told us that they had spoken to staff at a later occasion about the importance of maintaining professional boundaries, we saw that the registered manager had not completed a record of account of the incident, nor had they outlined any follow up action to be taken.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was able to tell us about their responsibilities in relation to the Duty of Candour and told us that they were open to feedback as it helped them to improve. However, records we reviewed indicated that people's concerns and complaints were not always addressed and resolved appropriately, and we found that ongoing issues such as staff timekeeping and poor medication records had not been effectively identified through audits and addressed. We found that the registered manager had not effectively addressed or investigated some concerns relating to staff conduct, nor had they yet set out clear expectations of staff in this regard. The registered manager told us that they had recently established a team of senior carers who would be responsible for setting objectives to develop and drive improvements in the service.

The registered manager had failed to ensure through auditing processes that appropriate records were maintained to reflect that care and support was being provided as required and that people's risks were always managed effectively. Systems in place to monitor compliance with the regulations were not effective and had failed to identify that compliance was not consistently achieved. For example complaints made by people who used the service or their relatives were not received and responded to as expected in a timely and robust manner. The registered manager did not effectively improve the service by learning from incidents and feedback to ensure that systems were robust to prevent further occurrences.

We saw that some people and relatives had raised concerns with the registered manager and staff in relation to staff timekeeping. While some relatives noted an improvement in staff arrival times to calls, we identified that this had a negative impact on some people's care and one relative shared their concern about the registered manager's overview of this ongoing issue. The systems in place had not been used to review or identify if timeliness of calls could be improved using the current staff group or if additional staff were needed. Gaps in people's care records indicated that staff had not turned up for their call, however some of the manager's records showed that these calls had been cancelled by people using the service at short notice. We also found that audits of people's daily care notes had failed to identify staff timekeeping issues and that records did not contain suitable guidance for managing specific risks presented by people's conditions. Audits had not identified when staff had failed to accurately and appropriately complete medicines records. We saw that the registered manager did not always take effective action to address concerns such as late calls and ensure improvements to the service were sustained.

Failure to have systems in place to effectively assess risks, together with arrangements to monitor and improve the quality of the service puts people at risk of receiving a service that is unsafe. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager at the service who had achieved a management qualification in July 2015. We saw that the registered manager had responded proactively to some safeguarding concerns and had followed processes appropriately. We identified however that the registered manager had not met their requirements in relation to informing us of safeguarding incidents and concerns that had occurred.

People and relatives we spoke with told us that they were happy with the service and that they would recommend it to others. A relative told us that they would recommend the service, "Because of how they look after my relative," and a person who used the service told us they "Feel so happy with [the care]." One person told us, "I can continue with my life and they help me to do it as good as it can be." A relative told us, "They're nice people and we have a laugh and a joke. They do everything that's required of them." A professional also told us that they would recommend the service and that it was well-led.
People told us that they were involved in directing how the service was provided through regular contact with the registered manager. One relative told us, 'The communication is good," and another relative told us that this had improved slightly. People and other relatives we spoke with confirmed this and told us that communication was good between them, the staff and the registered manager. The registered manager had a vision and values in place for the service and told us that their key goal was to deliver a quality-driven service that people wanted to use.

One staff member told us that the registered manager was approachable and that they would do, "The best they could to put it right" if staff had any concerns. Another staff member told us that the registered manager, "Always helps us and listens." Staff told us that they felt supported in their roles and the registered manager told us that they tried to encourage open communication with them so that they felt able to share concerns and ensure that mistakes were resolved rather than repeated. We saw one instance where a staff member had made an error and the registered manager had responded appropriately to this and ensured that all staff learned from the incident.

The registered manager told us that they referred to the regulations when developing policies and to inspection reports for examples of best practice. The registered manager told us that they had recently attended a safeguarding workshop and intended to attend more workshops to help maintain their social care knowledge and understanding. We saw that the registered manager had made some improvements to the service as recommended by a commissioner and that they shared social care information and resources with staff. The registered manager also emphasised the importance of reflecting on their practice and considering how things could be done better.

Staff told us that they would feel comfortable with their relatives using the service. One staff member told us that they would most definitely recommend the service, stating, "The staff are one of the best bunches of carers I could work with, they go above and beyond." Staff meetings were held and we saw that the registered manager contacted staff through written information about the requirements their role and the preferences and needs of the people who used the service. We also saw that staff members were praised for their work. The registered manager told us that they had made improvements to staff observation checks so that they focused on care and highlighted positive aspects of staff performance as well as areas of improvement.

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 The registered provider had failed to ensure the proper and safe management of medicines for people who used the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to establish systems that effectively assessed risks, together with arrangements to monitor and improve the quality of the service, which put people at risk of receiving a service that is unsafe.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there enough staff were effectively deployed to meet people's needs. The registered provider had failed to review or take action to identify if there were insufficient numbers of staff employed or if the deployment arrangements needed to be changed.