

Premier Care Limited

Premier Care Limited - Trafford & Manchester Homecare Branch

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

Premier Care Limited - Trafford & Manchester Homecare Branch is a domiciliary care provider. It provides personal care to adults and older people in their own homes. 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. At the time of our inspection the service supported 143 people with personal care.

People's experience of using this service and what we found

The service had continued to improve since the last inspection. Medicine concerns identified at the last inspection had been resolved. The risks associated with people's medicines were now managed safely. Further improvement was still required to ensure visit schedules were not impacting negatively on people's care.

The improvements implemented at the last inspection had been sustained. The staff culture was good and most staff we spoke to felt supported. The provider was working closely with the Local Authority and there was a schedule of audits in place to help drive further improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 25 October 2023) and there were breaches of regulations. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 1 March 2023. During this inspection the provider demonstrated that enough 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 carried out an announced focused inspection of this service on 29 & 30 August 2023. 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 and governance.

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 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 Premier Care Limited - Trafford & Manchester Homecare Branch on our website at www.cqc.org.uk.

Enforcement

We have identified a breach in relation to 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 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 with the 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Premier Care Limited - Trafford & Manchester Homecare Branch

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 2 inspectors and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. 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 was not a registered manager in post. They had recently left, and a new manager has been recruited and intends to submit an application to register.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 30 January 2024 and ended on 8 February 2024. We visited the location's office on 30 January and 1 February 2024.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (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 all this information to plan our inspection.

During the inspection

We spoke with 5 members of office staff, including 3 office coordinators and 2 area managers. We reviewed a range of records, including 4 people's care records and 9 medicines records. We looked at 3 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including quality assurance were reviewed. Two Experts by Experience spoke with 21 people and 9 relatives by telephone. We also spoke with 16 members of care staff by telephone.



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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always meeting the requirements we expect.

Staffing and recruitment

At our last inspection the provider had not established effective governance systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. 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.

- Despite some improvements, since our last inspection, late calls were still impacting on people who used the service. There were 567 calls in January more than 45 minutes late. This represented 50% of the total number of calls.
- Sixteen out of 30 people and their relatives, we spoke with, responded negatively about their call times. A relative told us, "[Relative] has been with them for about 2 years, the time of calls are terrible, I have to chase them up every other week as they are either too late or too early. One in 4 visits don't happen due to terrible timing" and "They know that I'm almost immobile and rely on my carers for nearly everything, I need a reliable routine. But Premier Care varies from day-to-day. When I ring to ask where my team is and why are they late again they say, 'Oh. We'll sort it out.' It might work for a day or even two but always goes wrong again."
- People did not always get their allocated time. 22% of calls in January were less than half the allocated time required to meet people's needs.
- We continued to receive negative feedback about carers when people's regular carers were not available. People told us, "I don't get regular carers, they often change. Sometimes I get a call to say they're going to be late, but not always, they have been up to 2 hours late. I get 2 visits of an hour each but I can't really plan anything because I can't trust their timings" and "My main carer is great but if [carer] is off they can miss the visits completely, they missed last week and I have to phone them constantly to see where they are and what time are they coming."

Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure safe systems for the management and administration of medicines. This demonstrated a continued breach of regulation 12 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 12.

- Medicines were managed safely. Good practice guidance was being followed, and effective systems were in place to ensure medicines were given as prescribed.
- Office staff had been trained to check the competencies of staff administering medication ensuring staff practice was safe.
- Training had been updated to include how to reconcile medicines when people are admitted to the service or have had medicines changed. Staff had undertaken this training and extra checks had been put in place to confirm changes were correct.
- We looked at records for 1 person who was receiving a time sensitive medicine. A process was in place which was being adhered to which meant they were receiving their medicines as instructed.
- For 1 person who received Paracetamol, we found the time interval between doses being given were too close together. This placed the person at unnecessary risk of side effects. Actions were taken during the inspection to correct this shortfall.

Systems and processes to safeguard people from the risk of abuse

- People were safeguarded from the risk of abuse. Issues of concern were dealt with promptly and there were clear systems in place to escalate concerns around refusal of care or self-neglect.
- Staff completed regular safeguarding training. They knew how to identify and report any concerns. The service had a whistleblowing policy in place and staff were confident reporting to outside agencies if required.
- The previous registered manager reported safeguarding concerns to the Local Authority and the Care Quality Commission in line with guidance.

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

- Care plans were up to date, and systems were in place to ensure they were reviewed and updated when required.
- Assessments had been implemented correctly and care plans contained sufficient detail to guide staff.
- An assessment of the environmental risks within each home was completed, for example, lighting and access to the property.

Preventing and controlling infection

- We were assured that the provider was using personal protective equipment (PPE) effectively and safely.
- Staff had received training in how to prevent and control infection.

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. The rating for this key question 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.

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

At our last inspection the provider's quality assurance systems were not robust enough to drive necessary improvements to people's care. This placed people at risk of harm and was a continued 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.

- As reported in the safe domain there was insufficient improvement in the management of visit schedules. This impacted negatively on people's care.
- The provider had an action plan in place to support further improvement in this area. Prior to our inspection the provider had identified poor practice contributing to late call times and had taken steps to address the issue.

The quality assurance system was not robust. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Concerns raised at the last inspection, about medicines administration, had now been addressed.
- Other improvements had been sustained and there was a clear audit system in place which was driving improvements across the service in all areas.

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 registered manager had left the service the day before the inspection. A new manager had been recruited and the provider was actively involved, to provide the necessary management support, in the interim.
- Improvements in the values and culture of the service had been sustained since the last inspection. Clear standards and expectations had been set and were supported by effective systems and processes.
- Most of the staff we spoke to were positive and told us the service had continued to improve and

mentioned the improvement to medicines systems in particular. Four staff expressed concern about the rotas and the support they received from office staff.

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 demonstrated an open and honest approach and was clear about the requirements of duty of candour and had notified the CQC and Local Authority safeguarding teams of any accidents and incidents as appropriate.

Working in partnership with others

- The provider was meeting regularly with the Local Authority quality team to support further improvement.
- Local Authority feedback prior to the inspection had been positive about the improvements made by 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 17 HSCA RA Regulations 2014 Good governance The quality assurance system was not robust. Late calls were impacting negatively on people's care.