Supreme Care Services Limited

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Supreme Care Services Limited (Greenwich) is a domiciliary care agency registered to provide personal care to people living in their own homes. At the time of this inspection the agency was providing a service to 54 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
During this inspection, we found some risk assessments contained limited information on what the potential risks were to people's safety and measures in place to mitigate the risks. Although the majority of people and relatives told us staff were punctual, there was some feedback where this was not the case. Feedback received also showed instances where staff did not always follow appropriate infection control practices. There were systems in place to monitor the quality of service, however some feedback indicated improvement was needed with communication.

The majority of people and relatives spoke positively about the quality of service they received. They told us they felt safe and staff knew their needs well. The provider had systems in place to record and respond to accidents and incidents. Any lessons learnt were used as opportunities to improve the quality of service.

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 18 September 2019).

Why we inspected
This was an 'inspection using remote technology'. This means we did not visit the office location and instead used technology such as electronic file sharing to gather information, and video and phone calls to engage with people using the service as part of this performance review and assessment.

We received concerns from the local authority in relation to late and missed calls, accidents and incidents/complaints not being followed up or dealt with adequately, lack of reporting to relevant bodies and management deployment leading to a lack of oversight.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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 Supreme Care Services Limited on our website at www.cqc.org.uk.

Enforcement
We have identified a breach in relation to risk assessment.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Supreme Care Services Limited

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating.

Unlike our standard approach to assessing performance, we did not physically visit the office of the location. This is a new approach we have introduced to reviewing and assessing performance of some care at home providers. Instead of visiting the office location we use technology such as electronic file sharing and video or phone calls to engage with people using the service and staff.

Inspection team
A single inspector carried out this inspection. They were supported by an expert 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.

The service had a manager registered with the Care Quality Commission. 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.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
This performance review and assessment was carried out without a visit to the location's office. We used technology such as telephone calls to enable us to engage with people using the service and staff, and electronic file sharing to enable us to review documentation.

We spoke with twenty people who used the service and twenty relatives about their experience of the care provided. We spoke with two members of staff including the provider, registered manager and quality manager.

We reviewed a range of records. This included six people's care records and medication records. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance and records relating to the management of the service.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management
• Risks to people's safety were not always assessed. Risk assessments and risk management plans were in place covering areas such as skin integrity and catheter care. However, some risk assessments contained limited information on what the potential risks were and measures in place to mitigate the risks to people.
• For example, the moving and handling risk assessment indicated a person was at risk and needed support with a number of mobility aids such as a hoist, wheelchair and slide sheet. Although the care plan detailed some information for staff on how this support should be provided, there was limited detail as to what the risks were with potential unsafe practices and measures to mitigate those risks.
• Falls risk assessments were in place, however the assessments were score tables which established the level of risk for each person and contained very limited information detailing what the risks were, what the measures were in place to mitigate the risk of falls and actions for staff to take should the person experience a fall. There were falls protocols in place for five people at risk of falls, however these were all identical in content and not specific to people's needs. We discussed this with the management team, and they advised, these had been discussed with people individually, however the information was not person centred.
• A person who was assessed as high risk in their falls assessment and required support with their catheter care was assisted by staff in the community. There was an escorting service plan in place, however this did not detail the risks to the person whilst out in the community, measures in place to mitigate the risks and actions staff would need to take should an incident occur whilst out in the community.

We found no direct evidence that people had been harmed as a result of the concerns we found. However, risks to people's health and safety were not always assessed or guidance available to reduce possible risks and maintain people's safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When speaking to people and relatives, they told us staff were aware of their needs and provided them with the support they needed to keep them safe from harm. One person told us "The carers know their job, so I feel perfectly safe when they are helping me wash, as I know I am not going to fall." Another person told us "[Staff member] checks me for pressure sores as I do sit (down) a lot now and she puts cream on them every day."

Staffing and recruitment
• Some improvement was required with the deployment of staff as we received mixed feedback from people

and relatives about punctuality particularly at weekends.
• The majority of people and relatives told us staff were on time and stayed for the full duration of the visit. A person told us "We have a good old chat when they [staff] come, and they always stay the time. I always get asked if there is anything else, they can do before they go as well."
• However, we received feedback of instances in which this was not the case. For example, a person told us "I had an issue with one carer who tends to fly in and out in about ten minutes when she turns up. I had another carer who is another one to fly in and out, but sometimes my frozen meals were not cooked right through. She was always in a rush." Another person told us "I have a regular carer during the week who is generally punctual but at weekend the quality of care is not as good."
• Relatives also told us "The timings are a little off at times. 9am call can be completed at 10.30am some days, but the carers usually call to explain why. [Person] has also had a few missed calls over the months. There have been about six or so in total" Another relative told us "There are two regular carers who are nice enough, but timings can be a bit hit and miss at times so some calls can be a bit earlier or later than is ideal for [person]. We don't always get a call to let us know either."
• We raised this with the management team, and they advised us of a number of measures in place to monitor timekeeping including an electronic system and a dedicated coordinator who monitored this daily. Records showed people and relatives were asked about staff punctuality and time keeping through telephone monitoring calls and spot checks and positive feedback was received. Actions were taken in response to improve timekeeping where needed. The director also advised they have undertaken a weekend care worker recruitment to ensure better consistency of care at the weekends.
•The provider followed safe recruitment practices and had ensured appropriate pre-employment checks were completed satisfactorily before staff were employed.

Preventing and controlling infection
• The service had an infection control policy in place. Staff had received training and had access to gloves, aprons and other personal protective equipment (PPE). However, we received mixed feedback in relation to staff adhering to good infection control practice. The majority of people and relatives told us staff always wore protective clothing when providing people with personal care. A person told us, "They [carers] always wear their PPE and they even use the foot covers now." A relative told us "…. they [staff] are very good in terms of COVID-19 precautions."
• However, people and relatives also told us of occasions where staff did not adhere to good infection control practice. A person told us "My Sunday carers had said they didn't need to wear masks but I am quite robust with them and make sure they wear a mask." Another person told us "I am slightly concerned that sometimes they [staff] used the same gloves after personal care and then proceeded to wash me. I have sometimes had to ask them to change gloves." A relative told us "They [staff] wear masks all the time and aprons when showering [person] but not at the rest of the time they are there."
• Records did show where there had been instances of staff not adhering to good practice infection control practice, actions had been taken by the service to resolve the concerns such as additional supervision and providing extra PPE to minimise reoccurrence.

Using medicines safely
• There were procedures in place to manage medicines safely. Medicines administration records (MARs) showed people received their medicines as prescribed.
• Medicines audits took place to ensure any discrepancies and/or gaps in recording on people's MARs were identified and followed up.
• Staff completed training to administer medicines and their competency was checked through spot checks.
• People and relatives spoke positively about the support they received with their medicines. A person told us "The [staff] do give me my medication and it's all written down in the book." A relative told us "They [staff] keep a close eye [on person's medicines]. [Person] is meant to have a tablet early in the morning. I

administer them but when the carers come in, they also check that I've given [person] there tablet and remind me if I haven't."

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. There were safeguarding and whistleblowing policies in place. Staff had completed safeguarding adults training and aware of the different types of abuse and reporting procedures to follow if they had any concerns of abuse.
• People and relatives told us they felt people were safe using the service. A person told us "Yes I do [feel safe] …. I feel completely safe. [Staff member] lets herself in, she's very good." A relative told us "Carers were very competent and [person] felt very safe.

Learning lessons when things go wrong
•The provider had a system in place to record and respond to accidents and incidents in a timely manner. Records showed any lessons learnt were relayed to staff through additional supervisions and refresher training and used to improve the quality of service to embed good practice.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• There was a number of audits in place to monitor the quality of service including call monitoring, medicines, spot checks and record keeping. However, we found improvement was needed with risk management and although the relevant policies and procedures were in place, there was mixed feedback received in relation to staff deployment and infection control.

• People and relatives spoke positively about the quality of service. A person told us "[The service] is very very good, and I am very pleased with the quality of the service." A relative told us "They check on the carers, they take the notes….the communications are good….the service is excellent. No issues. They are brilliant…."

• However, feedback indicated some improvement was needed with communication. One person told us "I did call the office about a missed call and they spoke with the carer concerned. The office hadn't passed on the information she needed to get past that. They need to communicate better with carers, or they can't do their job." A relative told us "I would recommend them, but they really need to up their game on the communications generally and especially with staff."

• People and relatives also told us they didn't know the office staff. People told us "I don't get any calls from the office, so I couldn't tell you who runs the place" and "I don't get calls to see if everything is ok. I only deal with the carer really." A relative told us "I don't know anyone at the office…I haven't the foggiest idea who the manager is."

• We raised this with the management team, and they advised they were surprised with the feedback as their internal auditing showed the majority of feedback was positive. An introductory letter from the registered manager had been sent out to people and relatives advising who they were and their contact details. Records we reviewed showed feedback obtained from people and relatives through telephone monitoring and spot checks was positive.

• The registered manager and provider understood their responsibility under the duty of candour and took responsibility when things went wrong. We noted communications to people and their relatives including the local commissioning authority which showed the registered manager provided apologies and reassurances that action was being taken to minimise the risk of any reoccurrence of such events and any issues were resolved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

• The provider obtained feedback from people and relatives about the service via telephone monitoring calls and visits. Feedback was analysed to ensure they improved the service where needed. A person told us "I had been allocated a female carer and contacted the office asking for a change of carer and they sent me a male carer who I much preferred. A field supervisor came to check my care needs were being met, If I were to rate them, I would give them four out of five stars."

• Staff meetings were held to discuss the management of the service. Minutes of these meetings showed aspects of people's care were discussed and staff had the opportunity to share good practice and any concerns they had.

Working in partnership with others

• The service worked in partnership with key organisations including the local authorities that commissioned the service and other health and social care professionals to provide effective joined up care. A person told us "I did have a fall once just before the carers were due to arrive. I had used my Lifeline, but they checked the ambulance was on the way and stayed with me until they arrived and kept me warm and comfortable."

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 Risks to people's safety were not always assessed or guidance available to identify and reduce possible risks