Premier Community Care Limited

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Inspection report

Wansbeck House
88 Cockton Hill Road
Bishop Auckland
County Durham
DL14 6BE

Tel: 01388458991
Website: www.premiercommunitycare.com

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22 August 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 10, 11 and 22 August 2016. We gave the provider 48 hours' notice to ensure someone would be available to talk to us.

Premier Community Care Limited was last inspected by CQC on 22 September 2014 and was compliant with the regulations in force at that time.

The service provides personal care to people in their own homes. On the day of our inspection there were 473 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Risk assessments were in place for people who used the service and staff described potential risks and the safeguards in place. Accidents and incidents were appropriately recorded and investigated.

The registered provider's safeguarding policy defined the procedures to be followed upon discovering abuse or suspected abuse and the registered provider understood safeguarding procedures and had followed them.

Appropriate procedures were in place to ensure people received medicines as prescribed.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and consent was obtained from people who used the service.

Staff were aware of people's nutritional needs and care records contained evidence of involvement from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care provided by the service. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person centred way.

People who used the service, and family members, were aware of how to make a complaint.

Staff felt supported by the management team and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service. Family members told us the management team were approachable and understanding.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and the registered provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated, and risk assessments were in place for people and staff.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff regarding their diet and nutrition needs.

People had access to healthcare services and received ongoing healthcare support.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People had been involved in writing their care plans and their

wishes were taken into consideration.

Staff received training in end of life care and people's end of life wishes and instructions were recorded.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

People were protected from social isolation.

The registered provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The registered provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the management team were approachable and they felt supported in their role.

Premier Community Care Limited

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 10, 11 and 22 August 2016.We gave the provider 48 hours' notice to ensure someone would be available to talk to us. One Adult Social Care inspector took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. No concerns were raised by any of these professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with seven people who used the service and one family member. We also spoke with the registered manager, human resources manager, care plan supervisor, training and quality coordinator and three care workers.

We looked at the personal care or treatment records of seven people who used the service. We also looked at the personnel files for five members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe with staff at Bishop Auckland. They told us, "Yes, second to none", "Perfectly safe" and "They make sure I'm safe".

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We were unable to see the proof of ID records for two members of staff as they had been archived. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the human resources manager who explained the service had a telemonitoring system, which was used by staff on every visit and enabled management to monitor late and missed calls. The human resources manager told us a system was in place for staff to report absences and an on call care coordinator was available out of hours to deal with any emergencies or staff absences. Staff we spoke with confirmed this. All staff absences were covered by the permanent staff team. Staff told us, "We all seem to rally together and help out when we can."

People who used the service told us they did not have any concerns about the staff or staffing levels and told us, "They [staff] always turn up on time" and "They [staff] usually come on time. Sometimes a little early but I prefer it that way". This meant staffing levels were appropriate to meet the needs of the people who used the service.

The provider had a risk assessment policy, which described the responsibilities and processes to follow when identifying, evaluating and managing risk. Risk assessments were in place for people who used the service and staff, and described potential risks and the safeguards in place. Risk assessments included care staff/lone worker safety, home environment, personal care, hygiene and well being, mobility and risk of falls, nutrition and diet, personal safety of the person who used the service, mental capacity, and sight, hearing and communication. Risk assessments described the identified risks, risk score and requirements of care staff whilst respecting the wishes of the person to take the risk. For example, one person was at high risk of falls due to being unable to weight bare. Staff requirements included ensuring a safe environment, following health and safety and moving and handling policies and using equipment safely and correctly.

The provider had a lone worker policy, which was in place to ensure safe systems of work for staff working on their own. An office risk assessment was in place, which identified hazards to staff in the workplace.

The service had business continuity plan, which was in place to prepare the business to cope with the effects of an emergency. For example, adverse weather conditions, theft or vandalism, fire, power outages, loss or illness of key staff and outbreak of disease or infection. For each identified potential hazard, the level of impact, effect on the service and resources required for recovery were recorded.

We saw a copy of the provider's safeguarding policy, which defined the procedures to be followed upon discovering abuse or suspected abuse. We looked at the safeguarding file, which included a copy of the local authority risk threshold tool and procedure to follow to report a safeguarding incident. We saw records of safeguarding incidents, which included copies of safeguarding strategy meeting minutes and statutory notifications submitted to CQC. The safeguarding index sheet included a record of each safeguarding incident, type of incident and outcome. We found the provider understood safeguarding procedures and had followed them.

The provider had a 'Reporting and auditing incidents' policy. The aim of which was to ensure accidents, incidents, near misses and notifications were monitored and appropriate action taken to improve standards. Accidents were recorded on individual accident report forms and recorded the details of the person involved in the accident, the details of the person completing the report, description of the accident and whether it was RIDDOR reportable. RIDDOR is the reporting of injuries, diseases and dangerous occurrences regulations 1995. Accident/untoward incident forms were also completed for every type of accident or incident, including medicine errors and missed calls.

An incident management index sheet was maintained and recorded each incident and the type of incident, for example, medication error, missed call, late call or standard of care. Incidents were analysed via a chart, which showed the number of incidents by type each month. This was used to identify any trends. For example, an increase in medication errors had been identified in September 2015. A new procedure was put in place to support staff via informal meetings and refresher training.

The provider had an infection control policy and staff were reminded about following the policy and using personal protective equipment (PPE) on visits. The practice of safe hygiene and the use of PPE was checked during care staff spot checks.

We looked at the management of medicines and saw a copy of the provider's medication policy. The policy explained that care staff were only allowed to assist with prescribed medicine and only trained and competent staff could carry out a medication risk assessment for each person who used the service.

Following a risk assessment, medicine administration would be defined as one of three levels; assisting people with medicines, prompting people with medicines and administering medicines. Where any assistance was given, staff signed a MAR sheet. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

We saw copies of medicine administration records, which included the name and address of the person who used the service, date of birth, details of any known allergies and GP and pharmacy contact details. The MARs recorded the medicine administered, strength and route, dose and frequency, and staff initials for each administration.

Medicine audits were carried out regularly and included any identified issues and actions taken. Where issues were identified, the majority related to missing initials on some of the records. Actions taken included discussions with staff and updated medicines training.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. Family members told us, "They [staff] go out of their way for you", "[Staff member] is on the ball", "[Staff] have worked tirelessly over the last couple of days to get things sorted for me. They've done a brilliant job", "Generally they are very good", "They [staff] are brilliant. I've not had any problems" and "Yes, I am happy with the service". A family member told us, "We have been very happy."

New staff received a staff handbook and completed an induction to the service, which included an introduction to the role, policies and procedures and shadowing an experienced member of staff. All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care. This meant new staff were all given consistent information required to understand their role.

During the first week of employment, staff received mandatory training from the registered provider's training and quality coordinator. Mandatory training is training that the registered provider thinks is necessary to support people safely. Training took place in the registered provider's own training room and included privacy and dignity, equality and diversity, working in a person centred way, communication, confidentiality and handling information, palliative care, mental capacity, fire safety, basic life support, safeguarding, medication, food hygiene, diabetes, fluid and nutrition care, infection prevention and control, care planning, catheter care, dementia awareness and health and safety. The registered provider's electronic training database recorded when training had taken place and when refresher training was due. Staff we spoke with told us they received sufficient training for the role and their training was up to date.

Staff received an annual appraisal. The registered provider maintained an 'Appraisal matrix', which recorded when appraisals were due and when they had been completed. Staff received regular supervisions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Spot checks of staff in the workplace were also carried out. These included whether the staff member stayed for the appropriate length of time, their communication was effective, they were dressed appropriately, they practised safe hygiene and proper food safety principles, medicines records were up to date and documentation was completed correctly.

People were protected from the risk of poor nutrition and staff were aware of people's diet and nutritional needs. One person who used the service had dysarthria and dysphagia. Dysarthria affects the person's ability to control the muscles in their mouth and dysphagia is difficulty or discomfort in swallowing. The person's care record described how all food and fluids were given via a percutaneous endoscopic gastrostomy (PEG). PEG is a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The person's family member supported the person with their PEG feeding however staff had received training in PEG feeding from a nurse. This meant staff could provide support to the person, allowing their family member time to go out.

Other people who used the service had meals prepared for them by care staff. For some people, staff would monitor the person to make sure they were eating and drinking, and prompt if necessary. For example, "Carer to support with meal and drinks on visits. Prompt food and fluids. Monitor intake, report and document any concerns asap."

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 can only be deprived of their liberty to 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. The care plan supervisor told us that although staff were trained in mental capacity, people's social workers dealt with any mental capacity assessments or best interest decision meetings and care staff were made aware of these via regular contact with people's social workers.

We observed that the service had sought consent from people for the care and support they were provided with. Signed 'care plan agreement' forms were in people's care records, which confirmed the information in the care records was correct. They also provided consent from the person who used the service, where agreed, to information being shared with other agencies and for care staff to have the access code or keys to the person's property.

Care records stated whether a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). DNACPRs were kept in the person's own copy of their care records.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of involvement from external specialists including GPs, district nurses and physiotherapists. Staff were aware of these contacts and carried out the advice given by such professionals.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care provided by Premier Community Care Limited. They told us, "I couldn't fault the carers, they do a superb job", "They are very caring. They cater for any of your needs", "[Staff member] is lovely" and "The lasses who come are brilliant".

Care records contained evidence that people had been involved in writing their care plans and their wishes were taken into consideration. For example, we saw the care records included a section where the person could say what name they preferred to be called. One person's care record described how staff were to place a flannel over the person' face whilst washing their hair as they disliked water and shampoo on their face.

The human resources manager had recently signed up to become the registered provider's dignity champion and other staff were invited to sign up too. The National Dignity Council 'Ten Dignity Do's' had been circulated among staff so they could be put into practice in the workplace. The human resources manager told us dignity was incorporated into team meetings, supervisions and appraisals, and staff were regularly asked if they had any concerns.

Staff told us that dignity was an important part of their role and explained how they respected people's privacy. For example, giving people privacy when they went to the toilet, covering people with a towel to protect their dignity and closing doors, especially if other family members were in the house. A staff member told us, "It's their home, put yourself in their position" and "Think of them as your family".

Care records described how staff were to respect people's privacy and dignity whilst carrying out personal care or other tasks. For example, "Needs undressing into night wear. Maintain dignity and respect at all times. Make comfortable in bed", "Carer to use front door. Knock loudly as [Name] is hard of hearing", "[Name] manages own personal care needs. Carer to monitor to ensure [Name] is changing their clothes regularly and maintaining personal hygiene" and "Carers to support with bed bath, washing and dressing. Maintain dignity and respect".

We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Oh yes, they are really good", "They do respect me and give me privacy" and "They respect [Name]'s choice. This meant that staff treated people with dignity and respect

Care records described how staff promoted independence and supported people to care for themselves. For example, "Promote independence where safe and possible to do so", "Prompt to use walking frame when mobilising" and "[Name] informs they prefer to remain as independent as possible with personal care needs".

People who used the service told us, "I like to be independent. I can get in and out of bed and shower myself." This meant staff supported people to be independent where possible.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the care plan supervisor, who told us none of the people who were using the service at the time of our inspection visit had independent advocates.

We saw how one of the people who used the service had received end of life care. Care plans documented what actions staff were to take on each visit. Staff received end of life care training as part of their induction to the service. People's bereavement wishes and instructions were recorded.

Good

Is the service responsive?

Our findings

The service was responsive. People's care needs were identified before they began using the service and care records were regularly reviewed and evaluated.

We discussed the referral process with the care plan supervisor, who told us they would create a care plan based on the information provided in the referral from the local authority. The care plan supervisor would then arrange to visit the person who used the service to complete the remainder of the care plan and consult with family members, the person's social worker and GP.

The registered provider's 'Care planning and record keeping' policy described how care plans were never made without the active participation of the person who used the service and the person would sign to say they agreed with the plan. We saw evidence of this in the care records we looked at.

Care records included a front sheet, which provided important information about the person such as date of birth, next of kin, GP, nurse and social worker contact details, and details of any other agencies involved with the person. The care plan supervisor told us if it was identified that people's health or care needs had changed, they would inform the person's social worker and any other relevant agencies and work with them.

Care records described the tasks care staff had to complete on each visit. For example, personal care, meal preparation, administration of medicines and social visits.

One person who used the service was spending time in bed due to a recent fall and hospital admission. A referral to physiotherapy had been made for the person to help build up their confidence around mobility and transfers. Staff were instructed to encourage the person to stand where able and get out of bed. Staff were also instructed to report any decline or concerns immediately, for example, monitor skin and pressure areas, apply prescribed cream and report to the appropriate health professional. This meant the service had in place person centred care plans which detailed specific care required by each person.

Another person who used the service had a number of health issues. The person used inhalers to help control chronic obstructive pulmonary disease (COPD) and used a catheter. COPD is the name for a collection of lung diseases. Care staff supported the person with catheter care, personal care, skin integrity, meals and ensured the person was managing and maintaining their personal hygiene. Staff were instructed to monitor the person's health, including skin pressure areas, and report any concerns to the appropriate health professional.

Care records described people's social interests and level of family involvement. Any requirements of care staff to support people in this area were documented. For example, shopping trips, visits to cafés and other accompanied activities.

The registered provider had a complaints policy and procedure, which described how every written complaint should be acknowledged within seven working days, and investigated and responded to within

fourteen working days. The complaints file, included a 'Complaint management' sheet, which was an index to the file and recorded the complaint number, date, type of complaint, staff and person who used the service involved in the complaint and any additional notes. From this complaint management sheet, we found there had been 28 complaints made to the service since 1 January 2016.

Each complaint was recorded on a complaint form, which included a full description of the complaint, details of the investigation and findings and a record of any action taken and practice improvements as a result of the complaint. The file also included copies of emails and records of letters to and from complainants, and letters sent to staff, informing them of allegations made against them and invitations to investigation meetings and disciplinary hearings.

People, and their family members, we spoke with were aware of how to make a complaint. This showed the registered provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager and human resources manager about what was good about their service and any improvements they intended to make in the next 12 months.

The provider had signed up to the Social Care Commitment, which is the adult social care sector's promise to provide people who need care and support with high quality services. The provider was also accredited with the Investors in People scheme.

The service had a positive culture that was person centred, open, inclusive and empowering. Staff we spoke with felt supported by the management team and told us they were comfortable raising any concerns. They told us, "If you need to speak to anyone, there is always someone there", "Good support", "You can go in with any problem you've got", "Someone is at the end of the telephone if you need them" and "Truly there is [an open door policy]". A family member told us, "I have a good relationship with the manager and office staff."

Staff were regularly consulted and kept up to date with information about the service and the registered provider. Staff meetings took place regularly in each of the four local areas covered by staff. We looked at the minutes from the most recent meeting held on 20 June 2016 and saw topics of discussion included health and safety, safeguarding, rotas, cancelled calls and communication. The registered provider also held 'Carer representative' meetings which involved a staff member from each of the local areas covered by the service attending a meeting with the human resources manager.

A staff satisfaction survey took place on an annual basis. Survey questions included whether staff were satisfied in their role and with their terms and conditions, whether the service was a supportive and friendly place to work, how satisfied staff were with support and managerial direction, what the best things about working for the provider were and what could be improved.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it.

The registered provider completed a monthly management report. This recorded the number of new and cancelled contracts, human resources information, number and types of incidents, complaints, safeguarding incidents and accidents. Management reports were analysed on a quarterly basis and the results were included in quarterly human resources reports, which went into more detail about recruitment and selection, sickness and absences, disciplinary issues, staff development and any recommendations from any of the areas. For example, in the January to March 2016 report it was identified that 30 employees had left the company and only 12 new recruits had been taken on in the same period. Recommendations were made regarding advertising, new part time shift patterns and the allocation of care visits to reduce travelling time.

'Team leader monthly monitoring' forms were completed for each person who used the service. These included a check of medicines, health and safety and care planning. Notes recorded whether care needs were being met or whether there were any identified issues. Issues were flagged to the care coordinator. For example, it was identified that one person's mobility had declined and the family and occupational therapist were aware and had supported the person. The person had been issued with a support frame but was refusing to use it. Care staff were advised to encourage the person on a daily basis to use the frame.

'Service user questionnaires' were carried out for each person who used the service on at least an annual basis. A team leader visited the person in their own home and asked them a series of questions, for example, do the care staff arrive on time, is the person happy with the care they receive, is the person treated with respect and is their privacy and dignity respected, is the person happy with the staff and any other comments they would like to add. The person who used the service had signed the questionnaire to say they agreed with the content. Any identified issues were addressed by the provider.

People who used the service, and their family members, told us, "I have reviews", "They visit me and ask me questions" and "They always ask if we are happy with the service and if there's anything we need".

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.