Premier Care Limited

Premier Care Limited - Cheshire West & East Branch

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We started an announced inspection on the 12 October 2016 and visited the office premises over three days. As part of the inspection we spoke to people who used the service and visited some in their own homes.

Premier Care Limited is a domiciliary care agency which provides support and personal care to people in their own homes. The agency is based in Tarporley but provides support within the surrounding rural areas and up towards Neston and Ellesmere Port. At the time of the inspection the registered provider told us that they provided around 1240 hours of the regulated activity of personal care to approximately 140 people.

The service did not have a registered manager. 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.

We had previously carried out an unannounced comprehensive inspection of this service on 24 February 2016 and found breaches of legal requirements. The purpose of this inspection was to check if the registered provider now met legal requirements and to ensure that people who receive the service are provided with safe and effective care.

The registered provider had submitted an action plan telling us they would be compliant by September 2016. However, we found that the registered provider was still not meeting legal requirements and we identified a number of on-going and new breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People who used the service told us that they were not satisfied with the care that they received. They said that the care staff were polite and caring towards them but that the overall service was unreliable, inconsistent and as a result they did not feel safe. People commented that they never knew who was coming to provide the service, there were many occasions when care staff were late and it was not unusual for no one to turn up at all.

People were supported with their medication but we found that this was not done in a safe way. People did not always get their medication as prescribed or directed. This placed their health and wellbeing at risk.

An assessment of people's needs was not always evident prior to people using the service and people told us they had not really been involved in formulating their care plans. Not everyone had a personalised care plan in place and as a result, staff did not always deliver safe care in line with a person's wishes and preferences. This meant that people did not get care that afforded them privacy, dignity and respect.

The registered provider did not ensure that their own policies and procedures were adhered to in regards to recruiting staff. Not all staff had the required checks prior to the commencement of their employment. This meant that the registered provider did not ensure that staff were suitably skilled, had the right experience or were of the character to keep people safe.

Training provided to staff was inconsistent and supervisions were not regularly carried out. There was no direct observation or assessment of care staff therefore people could not be confident that care staff were competent and skilled to carry out their role. People told us that new staff needed more training and support in order to support them more effectively.

People's complaints were not identified as such and addressed. People's views of the service were not always formally recorded and we found no action was taken when issues were raised. People told us that they were not listened to and action was not taken to prevent any unsafe or inappropriate care that was being reported.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and to report on what we find. Staff gained consent from people prior to providing care or services, however where people lacked capacity we saw that arrangements were not in place for staff to act in their best interests. Staff were not knowledgeable about the MCA and had not received training. This meant that there was a risk that support was not being provided in a manner that protected people's rights.

We found that personal and private information about people was not kept securely and there were occasions where there were other breaches of confidentiality. This meant that privacy and dignity were not maintained.

Quality assurance checks on care plans and care delivery were ineffective. Audits had not been carried out .This meant that the risks to people's health, safety and welfare had not been identified or addressed in a timely manner. The registered provider had also failed to notify the CQC about key events within the service that impacted on the health and welfare of those being supported. Due to the many concerns that we found, we did not have confidence that the registered provider had oversight of quality and risk within the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not receive safe care and treatment. They did not always have the right level of support required at the time they needed it.

The management and administration of medicines was unsafe and placed people at risk of harm.

Recruitment policies and procedures were not followed and so there was a risk that people received support from people not deemed to be of suitable character and skill.

Is the service effective?

Inadequate

The service was not effective.

The service did not follow the principles of the Mental Capacity Act and its code of practice. This meant that care may not be always be provided with informed consent.

Staff did not receive a robust induction, training or the support required in order to ensure they were competent and confident in their roles.

People did not receive the supported they required with diet and fluid intake.

Is the service caring?

Inadequate

The service was not caring.

People and their relatives were not provided with a reliable and safe service. This meant that there were times when they were left anxious or upset.

People were not treated with dignity and respect as care was not delivered in line with their wishes and preferences.

Staff did not assure that a person's confidentiality was maintained.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive support that was reliable, consistent and met their individual needs. Person Centred Care plans were not available to support staff in meeting personal choices and preferences.

Complaints were not always identified or responded to. Lessons were not learnt from complaints and issues were not resolved to a person's satisfaction.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager. The registered provider had not made the improvements required at the last inspection to ensure that this was a well-led service.

People and their families said that they had lost confidence in the registered provider and did not feel that their concerns were responded to.

There were quality monitoring systems in place but they had not been used effectively to identify and address concerns.

The registered provider failed to notify the CQC of significant events within the service and also failed to display its rating for the public.

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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.

The inspection commenced on the 12 October and took place over a number of days as we visited the office, saw people in their own homes and spoke to others on the phone.

The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection was carried out by an adult social care inspector.

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 also looked at the notifications we had received from the registered provider, we considered questionnaires completed by people who used the service and also other information CQC had received about the registered provider.

We also spoke to both local authorities that commission care from the Registered Provider and also the Safeguarding Unit for Cheshire West and Chester. Some concerns were raised in regards to the quality and safety of the care provided.

We spoke with 16 people using the service, their relatives and friends on the phone or by visiting them within their own homes.

We spoke with nine staff at the office or by phone to seek their opinion of the service and to talk to them about their roles.

We reviewed records relating to the service such as staff rotas, training records, recruitment files, staff records, quality audits, complaint logs, policies and procedures.

We also looked at records relating to people who used the service such as care plans, medication administration records and daily logs.

Inadequate

Is the service safe?

Our findings

People stated that the punctuality and reliability of care staff was consistently poor and this left them feeling unsafe and vulnerable. Comments included "The office rarely lets me know if someone is running late or not going to come at all", "They [care staff] can be anywhere between half an hour to four hours late", "Its pot luck if and when they turn up" and "I never know who is coming and I don't think the staff know until the last minute either".

On the last inspection we had concerns about the management and administration of medication. We set the registered provider a requirement action and they provided us with an action plan stating improvements would be made by September 2016. We found that no improvement had been made and people remained at risk of not receiving their medication as prescribed.

Some people told us that errors had been made with their medication. One person recalled "Staff do not always check properly. Once had to stop the carer as they were about to give me six tablets: I only take two at night. They were about to give me my morning medication". Another situation had arisen where the wrong medication had been given at the wrong time: this had been subject to a safeguarding investigation.

We looked at the records of people who required support to ensure that they took their medication in a safe way. Care plans did not accurately reflect the support a person required in order for staff to deliver the correct level of intervention. Care plans did not address a person's capacity or consent in regards to their medication being given by care staff.

Medicines Administration Records (MAR) were kept but not subject to regular review to ensure the arrangements were effective. MARs were handwritten, some were not legible and they did not record the signature of the staff member who had completed it. Not all MARs met the required standard as they did not record the person's name, stock of boxed medication available, date, time or dose required. For example: one person just had "Patches" written on the MAR. The MARs are were not checked for accuracy by another trained and competent person to ensure that they contained the correct information.

Records kept were not accurate. For example, there were missing signatures on MARs yet daily records indicated that medication had been administered. Other daily records did not reference the administration of medication and neither did the MARs. None of these issues had been identified, highlighted or investigated to establish if there was a recording error or whether in fact the person had not received that treatment. Other medication had been signed for but not given as it was still available in the blister or the box. We found one person had a number of tablets that had not been given over a 2 week period.

There was no information in the MARs or care records to direct staff as to the use of creams, patches, or eye drops. Therefore there was a risk that staff would now know where or how to correctly apply them. The health of people using the service is placed at unnecessary risk of harm when medicines records are inaccurate.

Sometimes staff supported people with medicines that were prescribed to be taken as when as required (PRN). People did not have a care plan in place to indicate to staff the circumstances in which this medication should be given. Where a variable dose was prescribed, there was no guidance as to how much medication should be given. Staff failed to record what had been administered where a dose was variable and did not record the specific time it was given. This meant that people could be administered more medication than recommended over a set time period. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently and in line with their individual needs and preferences.

We saw that medication needed to be given a set time apart or needed to be given before food. Staff did not have information available to state what arrangements they needed to make be sure they gave medication at the correct time. We saw that on one occasion a care staff had written "Medication given with food" when it was required 30-60 minutes before food.

Staff told us they had infection control training, and that the service always ensured that disposable gloves and aprons (PPE) were supplied to the person's home for their use. However, people and their families told us that staff did not always wear aprons and that gloves were not always changed after carrying out personal care. Incontinence products and PPE were not always disposed of appropriately.

There was a policy in place to record accidents and incidents. The accident book we were shown contained no information since 2015. We asked the registered provider to review this further as it was unlikely that there had been no reportable incidents since that time. There had also been no notifications made to the CQC.

There was a lack of risk assessments undertaken to protect the health and welfare of people who used the service and staff. An environmental risk assessment was not always in place to ensure staff were working in a safe environment.

Risk assessments were not always carried out in regards to key aspects of person's care and support. Not all care plans indicated concerns around a person's mobility, medication, skin care and the equipment they used. There was insufficient and unclear information about the risks to a person's health and safety. For example, in one care file there was a lack of clear information about a person who was diabetic. There was insufficient information for staff to take an consistent approach to support which involved the monitoring and recording of blood glucose levels (BM's) and the supervision of insulin administration. There was no risk assessment in place to guide staff as to what were the risk factors for someone with diabetes, the symptoms of high or low blood glucose levels or the actions they would take should BM's be outside of the acceptable range. The risks associated with this condition had not been minimised as call times were variable and so medication or meals were not being given at the specific times required to keep the person well. Care Plans or daily logs also indicated that a person may be at risk of falls but there was no risk assessment or management plan in place.

Records indicated staff had received training on how to assist people to move safely but there was no evidence of a practical session being carried out by a competent person. The registered provider had failed to demonstrate that they had checked that any equipment used by staff such as mobile hoists, stand-aids etc. was safe, fit for purpose and serviced by the person responsible.

People had access to emergency contact numbers if they needed advice or help from senior staff when the office was not open. However, comments from people and families were not positive. Comments included "It is difficult" or "It's fairly impossible" to make contact with the office. This left people with an increased

feeling of insecurity. A number of people outlined situations that had left them vulnerable but they had not been able to contact the office and so had to seek help from family or friends.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to make sure that care and treatment was provided in a safe way to people receiving care and support.

During the last inspection, we raised concern around the management and reporting of safeguarding matters. We issued the registered provider with a requirement notice and they provided us with an action plan stating that improvements would be made by 5th September 2016. Improvements had not been made.

There were revised safeguarding policies and procedures in place. However, these did not describe to senior staff how to manage any potential safeguarding concerns appropriately. We found that two safeguarding matters had been inappropriately managed by senior staff which could have resulted in the tainting of evidence if any criminal action had been taken. This demonstrated, as on the last inspection, that senior staff were not always aware of when and how to involve social services in relations to safeguarding concerns.

Staff spoken with knew how to raise concerns with the manager. However, they lacked an understanding of what was a potential abuse allegation or the role of outside agencies such as social services. Staff had also taken inappropriate action without questioning the instruction given to them by a senior member of staff.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not developed systems and processes that operated effectively to prevent or respond to allegations of abuse for people using the service.

All the people we contacted said that at some point the care staff had missed a visit or been late. Comments from people included: "I never know if they are running late so you just have to sit and hope they turn up", "I worry that I have been forgotten about sometimes as no one tells you if staff are going to be late or not come at all". Relatives echoed these comments and felt that the service was unreliable and placed a person at risk. Comments included "It's a lottery: will they or won't they come?" and "I never feel I can go away as I have no faith in the staff to turn up".

Some people, in one geographical area, said that they had regular and reliable carers but that things were not always covered when staff were sick on or holidays. Another person said "They struggle to fill in gaps. I sometimes get a call and the office ask me I if can manage by myself as staff are sick or on holidays".

Care staff said there were insufficient numbers to fulfil their current commitments and this was worse at weekends. They stated that they were not given adequate travel time and that calls were planned 'back to back' which meant that they either had to reduce the planned call time or run late. Others reported having to be in two places at once. Rotas that we looked at confirmed this with staff having back to back calls and no travel time: and some calls were quite a geographical distance apart. Staff said that if they were unavailable there was no guarantee that their calls could covered by other staff. They told us that sometimes they would get notified of changes to their rotas in the early hours of the morning or sometimes whilst carrying out a call. They were not asked if they could take on additional visits: but these just appeared on the rota.

The registered provider felt that there were sufficient numbers of staff and that the issues were created due to poor management of the rota system. However, they could not evidence that there were enough staff to

meet the needs of the people supported. On the week of the inspection there were in excess of 100 calls still unallocated for the following week.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not demonstrate that they employed sufficient numbers of staff to meet the needs of people.

Following the last inspection, the registered provider assured us that they could make improvements to their processes to ensure the robust recruitment of staff. People were not kept safe because the staff that provided support had not been through the appropriate recruitment checks. The registered provider had failed to follow their own recruitment policy.

The registered provider had undertaken an audit of staff files and highlighted that staff did not have appropriately completed application forms, interview notes, or references. In one case, we saw that a referee had stated that they would not reemploy a person but no further action had been taken to follow this up. Where references did not have a company stamp or had been submitted from a personal email address, these had not been verified. The registered provider told us that staff never started prior to the service receiving a check from the Disclosure and Barring service (DBS) and that their system did not allow for payment of wages without this check. We found that this was not the case. Staff had entered "fake" DBS numbers in order to override the system. This meant care staff had started work without this security check. People were placed at risk as they could not be assured that they were being supported by care staff deemed of suitable character and skill to work within social care.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to ensure that adequate steps had been taken to make sure that only "fit and proper" staff were employed.

Inadequate

Is the service effective?

Our findings

During the last inspection, we raised concern around the application of the Mental Capacity Act 2005 (MCA). We issued the registered provider with a requirement notice and they provided us with an action plan stating that improvements would be made by September 2016. Improvements had not been made. In discussion with staff they were unclear as to how to make sure that they obtained appropriate consent for people and had still not received any training in the MCA.

We checked how the service followed the principles of the MCA and its associated code of practice. 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, who had assumed mental capacity around care decisions, told us that staff did speak to them about their care and did not make them do anything they felt uncomfortable doing. Relatives of people who had cognitive impairment were concerned that sometimes staff did not understand that persons' could not give valid consent or a reliable response. For example: a person was not able to recall having a wash, changing their incontinence products nor having a meal. Rather than using a directional and persuasive approach, staff failed to carry out tasks when a person had said they had completed them.

As at the last inspection we found that the service did have a policy on consent but that some of the information in this conflicted with other sections and was confusing in its guidance to staff. We saw that care records made no reference to people's capacity and a number of people had been diagnosed with conditions that could potentially impact on their mental capacity to make decision. There was no information for staff as to when to support people to make decisions and no information that informed staff if a person lacked capacity or who had the legal standing to make decision on their behalf.

A number of people required support with medication from the staff, however there was no evidence that they had consented to this or that decisions had been made in their best interests where they were unable to manage their medication safely. Assessments undertaken by the service prior to commencing the support did not determine if the person had given informed consented and whether decisions had been made in their 'best interests'.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider failed to ensure that care and treatment was provided only with the consent of the relevant persons.

All staff must have an induction programme that prepares them for their role. The registered provider had a three day induction course. However, there was no knowledge check as to how staff then put this training into practice. From April 2015, any induction programme should meet the requirements of the "Care Certificate". The Care Certificate looks to improve the consistency and portability of the fundamental skills,

knowledge, values and behaviours of staff. No staff had been enrolled on the Care Certificate. The registered provider informed us that they were in the process of getting their current induction programme accredited.

Not all of the staff had any previous background of working in the care sector. This meant that they may not have the skills, knowledge and values to provide safe and effective support. An assessment of the learning and training needs of staff should be carried out at the start of employment and reviewed throughout. There was no initial assessment evident on any of the records that we viewed and the registered provider confirmed that this was not done. The registered provider told us that they did not formally assess or record when a staff member had achieved the level of competency required to work on their own. This meant that the registered provider could not be assured of the skill level of the staff providing support.

Staff confirmed that the level of initial support or shadowing was variable and some felt they had been left vulnerable starting their role without the skills to do the job. This was supported by people and relatives who reported having to show new staff how to use incontinence products, change catheter bags, use slide sheets or stand-aids.

Some aspects of a staff member's role (such as moving and handling or medication administration) required a practical competency assessment of their skills to ensure that staff understood the principles of the training and could follow it. The registered provider confirmed that there was no check carried out as to how effective the training had been. Moving and Handling training was not delivered by staff members who were deemed to be "competent" as their own "train the trainer" qualification was out of date. We therefore could not be assured that staff were up to date with current practice. We were not assured that all staff had the relevant skills and knowledge to meet people's needs and people were at risk of not having the correct support.

Staff had received "class room" training in how to administer medication but the registered provider confirmed that staff were not observed and assessed as being competent in their day to day work. Where medication required a specialised route such as eye drops, creams, inhaler or transdermal patches there was no evidence that staff had received direction from a clinical practitioner to ensure competence. This meant that people were at risk of harm as staff had not been trained and therefore could accidentally cause harm.

Staff informed us that they did not receive supervision on a regular basis and some new staff had never had supervision. Supervision provides an opportunity to review the work of staff, to offer guidance and support and to monitor progress in meeting development plans. The trainer had now been asked to carry out supervision with the staff and we saw that this was now being completed. The supervision log was not up to date.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to ensure that staff had the skills, knowledge and support to carry out their roles.

People's needs in relation to food and fluids were briefly documented in their care records. The amount of support required varied from person to person and was not always clear in the care records. Staff monitored but did not record the amount of food or what people had eaten and drank. There was no information in the care records that informed staff of what the person's preferences were, or how to make sure their preferences were met. The requirements of special diets were not indicated such as appropriate food or drink choices for a person with diabetes or someone taking Warfarin. Some relatives expressed concern that the food and fluid intake of people was being affected by the poor routine of the staff. One person said that

staff were supposed to help them with breakfast but records confirmed that sometimes they did not receive a call before 11.30am. Others said that there was insufficient time between calls and so as a result they did always feel like their next meal. We confirmed this to be the case through examination of the rotas and log books. For example: one person had a morning call at 10.15 and then lunch at 12 and another person had a call at 10.40 for breakfast then lunch at 11.55. This meant that there was a risk that people did not receive the support they required to maintain adequate diet and nutrition.

Inadequate

Is the service caring?

Our findings

People were positive about the support provided by staff and felt that any concerns were down to inadequate management. Comments included, "I'm happy with my carer 100% but the office management is rubbish", "The staff are caring and kind but the organisation is awful" and "I'm happy with the staff. Some are much better than others but it's not their fault they don't get the support". Relatives and people said that the only factor that stopped them from looking for an alternative provider was their relationship with the staff.

Staff said that ensuring people's needs were met was the most important thing to them. They told us that they felt frustrated, disappointed and embarrassed that they were not able to give people the time, consistency and continuity that they deserved.
People told us they were provided with information about the service and everyone had a service user's guide. This contained information regarding what they could expect from the service and how they would be cared for. People and relatives referred to this during our discussion but said that it was "A pity that the service did not live up to its promises".

Staff said they supported people to make choices, and adapted their approach in relation to people's needs. Staff were aware of the need to preserve people's dignity when providing care. Staff told us they took care to cover people when providing personal care, and helped people to dress their top half, for example, before washing their lower half. They also said they closed doors, and drew curtains to ensure people's privacy was respected.

People and families gave us examples of times where they dignity and respect was compromised by the organisation of the care.

Some people had a strong preference as to the gender of staff that they would accept. There was a note held on the rota to indicate this and to help the office staff with planning. However, this was not adhered to. One person said "They send a male and I have to send them away and struggle to see to myself. They know it's not what I want so why send them?" A relative said "We agreed to a male once as it was a desperate morning but now they seem to think its ok all the time and often send a male without asking if it is ok". Staff confirmed that they were aware of people's gender preferences and felt "bad" when the rota did not reflect this. One staff member explained that they knew they would get sent away for being the wrong gender and then worried how the person would cope without care.

Other people had asked that their calls not be attended by certain care staff members as they did not have confidence in them. This was logged on the rota system but this was not always adhered to. The registered provider said that sometimes due to staff numbers it was not always possible to arrange to rota for another member of staff to attend.

People and relatives spoken with appeared to be very much aware of some of the pressures faced by the registered provider and also performance issues in regards to staff employed in the service. Staff had not

maintained the level of expected confidentiality. One person said "My morning call was changed and I was not happy. Staff told me it was because [name] needed my time slot as they had a bus to catch. Why are they more important than me?" People were also aware of issues with other people who used the service and told us that staff often took calls from "on call" or the "office" during which the needs of others were discussed. Staff were also said to be asking the directions to other people's addresses as they had not taken time to plan journeys and find new locations. Information held about people was also not stored securely within the office. This meant that confidentiality and privacy was not maintained.

These are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to ensure that people's privacy was protected and that people who used the service were treated with respect and dignity at all times.

Inadequate

Is the service responsive?

Our findings

People and relatives stated that, in the main, individual staff were directly responsive to people's needs but that the organisation was not. Comments included "The staff are kind and helpful but the way they are organised is truly awful", "I don't always know whose coming", "I mostly get the same staff but if the regulars are away I dread it; more often than not they ask me if I can cope without", I don't like it when they send someone I don't know as there is no introduction".

People and relatives' comments about the reliability, continuity and consistency of care were confirmed by our own observations. No one that we spoke to received all of their care calls as planned. Everyone was able to readily recall incidents where care staff had been late or had not turned up at all. The majority of people said that this was now on a very frequent basis. We found that some "missed calls" had been deemed as "cancelled calls" by staff. For example, due to a lack of communication, one morning all the calls for one absent care staff member had not been covered. This had not been picked until people and families made complaints to head office, being unable to contact the local office. People were called around lunch time to ask if they wanted care but for most this was now too late. These calls were then deemed as cancelled as the person had turned down the offer of a late visit! Our inspection and a further audit by the registered provider highlighted that this appeared to be a standard practice within the service.

At the last inspection the registered provider stated that the care plan system was under review and it was their intention to make sure that care plans were more reflective of people's views in the future. They sent us an action plan and said that by September 2016 they were going to provide further training staff and computerise their care planning systems. We saw no improvements in the planning of people's care.

People and relatives told us that their wishes were not accommodated in the planning of their care. One said "It should be the person who manages the care but with Premier it's the care that manages the person".

Times were not consistent with a person's wishes around morning, lunch, tea or night routine. One person told us that their care could come any time between 9 and 1 which was not what they wanted. We looked at their care plan that indicated support was required with breakfast and morning routines. No time was specified but the rota confirmed the person's calls were not on the rota at a consistent time. Relatives also expressed concern that the timings of calls were not consistent. We looked at the rota for a person living with dementia that required a set and established routine. We found that the morning call was anytime between 8am and 11.20am and their night call varied from 21.30pm to 23.00pm. This was not in line with their needs and preferences.

Other people commented that staff did not stay the full length of time. They said that staff said they did not have enough time allocated or that travel time was not included. We observed and confirmed that this was the case. We found that one person was planned for 30 minutes care and this was important as they required time, supervision and support due to living with dementia. However, on occasion two staff attended for 15 minutes, telling family they were able to complete more calls in the overall time period.

None of the care records we looked at demonstrated a person centred approach. We found that some people did not have a care plan available at all. There was no explanation from the service as to why a care plan was not available.

The care plans were written as a series of tasks to be accomplished and did not take account of people's personal preferences, such as what particular food they liked to eat or what particular toiletries they preferred to use. Staff told us that people tended to tell them these things but did acknowledge that not everyone was able to tell them or had a relative available that could inform staff.

These issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to ensure that they did everything reasonably practical to make sure they provided person centred care appropriate to meet people's needs and preferences.

There was a complaints procedure in place but it was not effective. Prior to the inspection, CQC had received a number of complaints in regards to the service. We contacted these people again and no one felt their issues had been resolved. Other people, whom we met or spoke with during the course of the inspection, told us that they had made complaints but that "They fell on deaf years". Others told us that they had been promised meetings with senior staff members but these had never materialised. The registered provider had not ensured that lessons learnt from complaints were resolved in order to prevent the situation recurring. In discussions with staff, complaints were not always recognised by them or actioned which removed the opportunity for the service to address complaints and improve service quality. The quality compliance officer was in the process of trying to pull together all of the outstanding complaints and concerns in order to address the matters with individuals.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to identify or respond to or resolve complaints.

Inadequate

Is the service well-led?

Our findings

Without exception, every person and relative that we spoke with expressed concern about the overall management and organisation of the service. Comments included "All those in the office are useless", "The company is incompetent: they cannot organise a rota or get a bill right" and "It is a joke".

There is not a registered manager active at the service. Following the last inspection, the manager completed the registration process but then left the company. They have not yet cancelled their registration. The registered provider employed a replacement manager but they only had four days in post. The registered provider informed us that another manager and office manager would be starting in the second week of November. In the interim period, staff from "head office" were overseeing and dealing with the day to day management issues.

None of the staff we spoke with felt satisfied in their work. All the staff spoken with felt "disappointed" with a lack of support during and out of office hours. Prior to the inspection a number of staff had raised concern with us and as a result the registered provider had set up a number of staff meetings to address the concerns of staff in a particular geographical area.

People and relatives said that the response from the office was poor and staff never returned their calls or responded to concerns. They told us they often had to ring several times before they received an answer and sometimes gave up. The registered provider informed us that they had identified this as an issue and that staff who had been expected to be in the office from 8am had failed to do so. This matter had been addressed and they assured us that the office would be staffed at all times during office hours.

At the last inspection, we found that there was no quality monitoring of the care delivered. We set the the registered provider a requirement action and they provided us with an action plan stating improvements would be made by September 2016. We found that no improvements had been made.

There was no quality monitoring of the care delivered. "Spot checks" (a check on staff in people's own homes) were required as per the registered provider's policy however there were no arrangements for these to be undertaken at planned or regular intervals. The spot checks reviewed the staff appearance, arrival time, duration of call and interactions but not the care planned, management of medication or if the care delivered met the persons assessed needs. People spoken with confirmed that no one had come to observe the staff undertaking their jobs or to ask them their opinion of the service. Senior staff stated that they did not have time to do spot checks as they needed to make sure that all the calls were covered. Following the inspection, the registered provider commenced a programme of spot checks and staff supervision.

We discussed with the registered provider if there were any quality checks or reviews of health and safety such as accidents, the quality of care planning, medications, policies and procedures, handling of complaints, staff supervision or whether the views of staff and people who used the service were sought. The registered provider told us although there was processed in place these had not been followed and so there had been a lack of oversight.

The registered provider used a "real time monitoring system" which required care staff to "log in and out" of each call. In theory, this allowed the registered provider to monitor the time and duration of each call. However, there was no robust review of this system and we found that staff had made alterations and entries onto the system that did not accurately reflect what had occurred. For example, missed calls were renamed cancelled calls, staff had "forgotten" to log in/out and provided inaccurate information as to the time/ duration of the call. Some people told us that they had to challenge their bills as they were charged for care they had not received.

There was no robust system in place to ensure that daily log books and MARs were returned to the office for audit and scrutiny. We found that where books had been returned, they were stored in the office in a manner that was not secure and did not comply with Data Protection. Where an audit had taken place, there was no evidence that action had been taken to interrogate any concerns or discrepancies. This meant that errors with medication administration or missed calls were not highlighted and appropriate action taken.

Polices and procedures were in place but some of these required updating as they did not provide the staff with the information they required to fulfil their roles. Some of the policies still referred to the old CQC regulations.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not assess, monitor or seek to improve the quality and safety of the service provided.

At the last inspection, the registered provider confirmed that they had developed questionnaires for people. We looked at some of the returned questionnaires and found that the comments concurred with the issues found on the inspection. Where people had made comments about certain practices or staff, there was no evidence that these had yet been addressed through further supervision.

The registered provider must submit to us notifications of key events in the service such as deaths, safeguarding or serious injury. We found that the registered provider had failed to notify the CQC of all of these situations in a timely manner. This meant that the CQC was not able to monitor the events that affect the health, safety and welfare of people who used the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. (Part 4) as the registered provider failed to notify the CQC of key events within the service.

We could not find a display of the rating in the office nor on the website for the registered provider. People who used the service and their families had not been provided with a summary of the last report.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that their rating was displayed conspicuously at the location and on their website.