Premier Care Limited

Premier Care Limited - Wirral Branch

Inspection report

40 Mill Lane
Wallasey
Merseyside
CH44 5UB

Tel: 01516473458
Website: www.prem-care.co.uk

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30 November 2016

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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

Premier Care Wirral provides personal care for people aged 18 years or over who need care or support at home. At the time of this inspection 830+ people were in receipt of support from the service. The majority of people who used the service had their care funded by their local authority. There were also 80 people paying privately for their own care.

Prior to our visit, we had received information of concern about the quality and safety of the service provided. This information prompted our visit. We gave the provider of the service 24 hours' notice before our visit to ensure they would be available to participate in the inspection. We carried out the inspection on the 24, 25, 28, 29 and 30 November 2016.
There was a registered manager in post who participated in the inspection visit. 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'.

On the day of our visit the registered manager, compliance manager and one of the three directors of the service (the provider) in relation to how the service was managed were present during the inspection and were involved in the day to day running of the service also. We liaised with all three for the majority of our inspection.

During this inspection, we found breaches of Regulations 9, 10, 12, 13, 14, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We looked at the care files belonging to 14 people who used the service. 11 at the office and 3 in people's homes. We found they did not adequately cover people's needs and risks. They failed to provide clear information or guidance to staff in the provision of safe and appropriate care. This placed the person at risk of harm. Care plans were not personalised to people's individual needs and preferences and staff lacked sufficient guidance on how to provide people with person centred care.

We found that some people had mental health conditions which may have impacted on their ability to understand about the importance of their care in relation to nutrition. Staff had no guidance on how to support people with mental health needs and appropriate action had not been taken by staff to report the day to day outcomes of their visits.

Due to the irregularity of visits, some people did not receive their medication at regular times. People's medication administration charts showed gaps in the administration of medication that were unexplained and did not demonstrate that people always received the medication they needed or in a safe way. In some instances there were no medication administration record sheets (MAR's) in people's homes.

There was no evidence that the provider had checked on people's welfare or reviewed their care to ensure that the support people received continued to be suitable for their needs. Where people's support needs had changed, people's care plans had not been updated. This placed people at risk of inappropriate or unsafe care.

The staffing arrangements in place at the service was in disarray due to the amalgamation of three new contracts commissioned from July 2016 to October 2016 taking staffing up from 40 to over 430. The information provided to us was not a true reflection of the service provision at this time as the system 'Care Free' did not contain all of the data required as yet about all of the people using their service the impact meaning the provider could not be confident that people's needs would be met. The provider was aware of the staffing levels not being sufficient due to new contracts for being in place. Actions to review people's care to ensure that the number of staff employed could safely deliver the care required was taking place, however visits were being missed and the time agreed in care plans was not being provided.

There were gaps in the training of staff members and some training had not been updated since 2012 which meant it would have been out of date. This was due to staff transferring to the service without training records and the service not being aware of the staff competencies. Staff lacked appropriate supervision in their job role and their skills and abilities had not been regularly evaluated by the provider to ensure they were competent to deliver care to people to an appropriate standard.

People we spoke with told us that the staff who delivered the care were mostly kind and caring and did their best.

We saw that the provider did have a satisfactory complaint policy in place. However the provider's procedure was not effective in dealing with complaints made to them.

People's views about the quality of the service had not been sought by the provider. Four people we spoke with and three relatives told us that they had complained to the provider many times about the quality of the service and the care they received. One person said "They don't listen". Another said "I don't bother complaining anymore, they take no notice".

There were no effective audits in place to check the quality and safety of the service at this present time. The provider had failed to ensure the registered manager and staff followed policies and procedures, and had failed to take any action to protect people from risk.

During our visit on the 24, 25, 28, 29 and 30 November 2016, we raised serious concerns with the provider about the safety of the service and asked them to refer the care of some of the people whose care file we looked at to the local authority safeguarding team to protect them from further risk. We also asked them to take appropriate action to mitigate any further risks to people's health, safety and welfare. We asked the registered manager had they contacted the people we reported to them and they told us at a meeting they had not.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. 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.

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 said they felt safe with the staff who visited them but told us visits were often missed, late or irregular. This meant people were sometimes left without the support they needed when they needed it.

Risks in relation to people's care had not been properly assessed or managed. This meant people were not protected from harm.

Support for people who required assistance with medication was inconsistent. It was unclear if people received their medication in accordance with prescribed instructions and in some instances no information for staff was in place and they were acting in an unsafe manner.

We were not provided with the relevant information to confirm staff were recruited safely. Due to a high number of staff transfers into the service the records were sparse and needed to be checked to ensure staff were safe to work with vulnerable people.

Staffing levels were not adequate to meet the needs of the people using the service. This placed people at significant risk.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked any guidance on the risks and support people needed in respect of their mental health, care and welfare.

Some staff had not received appropriate training, supervision or appraisal. This meant the provider could not be confident staff were competent to provide safe care.

Due to the irregularity of people's visits around mealtimes, people's dietary needs and hydration needs were not always met as planned or at appropriate times for them.

Is the service caring?

Inadequate

The service was not always caring.

Some of the people we spoke with told us that they had raised concerns with the provider about the quality of their care but no improvements had been made. This did not demonstrate that the provider dealt with people's concerns in a caring and meaningful way.

People told us that they did not receive a call to check on their welfare when a visit was missed or late or advance notice that a call may be late. This did not demonstrate that the provider cared about people's welfare.

People we spoke with said the staff who provided care in people's own homes were mainly kind.

Is the service responsive?

Inadequate

The service was not responsive

Care plans and risk assessments were not person centred and failed to identify people's needs and wishes.

Personalised care was not delivered as people were not always supported at the times they wanted, with the care they needed or for the required length of time.

People's daily logs indicated that sometimes people's welfare was compromised by the lack of regular visit times, missed visits and inadequate time spent.

There was a complaints policy in place. The procedure was not effective the complaints received had not been documented or appropriately responded to.

Is the service well-led?

Inadequate

The management and leadership of the service was inadequate at this time.

There were no effective quality assurance systems in place to monitor the quality of the service or to mitigate any risk to people's health and welfare.

The systems in place in relation to staff shortages or with regards to the deployment of staff to ensure people needs were met safely was not effective.

The provider had not always notified the Local Authority or The

Care Quality Commission of notifiable incidents such as safeguarding incidents, serious injuries or staff shortages so people could be protected from further potential harm.	

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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.

This inspection took place on 24, 25, 28, 29 and 30 November 2016. The first day of the inspection was unannounced. The inspection was carried out by three adult social care inspectors.

Prior to our visit we had received information of concern from people who used the service and the relatives. We looked at any information we already had about the service and information we had received since our last inspection.

At this inspection we spoke with ten people who used the service, three relatives, seven care co-ordinators, three business administration staff, twelve care staff, the compliance manager, the registered manager and one director of the service who was 'the provider'. We looked at a variety of records including 14 care records, people's daily logs, six staff records, staff training records, a range of policies and procedures, a sample of medication administration records and other documentation in relation to the management of the service.

We visited people's homes during our inspection to talk to them about the care and support they received. We planned to visit and talk to ten people but unfortunately due to people's needs and care, access was not always possible.

Inadequate

Is the service safe?

Our findings

People we spoke with had mixed feedback about the service. They all felt safe with the staff who visited them but the majority of the people we spoke with told us that visits were often missed or late.

We looked at 14 care files belonging to people who used the service and a sample of their daily logs and planned and actual records. This information records the actual date, time in and out of visits and the support provided. We found that people's daily logs were not adequately maintained, in place or completed after each visit and the times reflected in the planned and actual visit records had a lot of anomalies. This meant it was not clear whether people actually received the care they needed.

The daily logs we looked at confirmed what people had told us in respect of late or missed visits. Records showed that people's visits were regularly late, too early or missed altogether. A significant proportion of people's visits did not take place at the planned time and staff did not regularly stay the amount of time agreed. This meant that people's needs were not met as planned. We also found that the majority of late and missed calls were not followed up consistently by the provider to ensure people were safe. This placed people at risk of harm.

We asked the provider how calls were monitored to ensure people received the care that they needed. They told us there was an electronic monitoring system in place called 'Care Free' that enabled staff to check in and out of visits via their mobile phones provided by the service. When we enquired further about how this system was used to monitor the visits planned and undertaken we were told that the electronic data was not looked at in this way. This meant that the provider did not use the electronic data to track late, missed or irregular visits to mitigate any risks to people's health and welfare and ensure they received the support they needed.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to provide care in a safe way that prevented avoidable harm or risk of harm.

We asked the provider for staff rotas. This was provided as part of the planned and actual times documents requested for each person we were case tracking. When we asked how staff members knew which visits to undertake each day, we were told that that workers received a list of visits each day via the 'Care Free' system to their mobile phone. We asked the provider how they knew which staff member was allocated to which visit each day. They told us that the staff members had some regular people they visited and were also allocated more people's care on the system they said is 'live' hourly/daily. That meant that staff rotas changed from the start of their day due to there being over 1000 hours of unallocated care work that required the service to meet. The provider and registered manager told us that they were still in the process of sorting out the actual times for people's care as they did not have all of the relevant information required due to them accepting three new contracts from the Local Authority.

We asked the provider what information they were able to access from the 'Care Free' system to show that

visits were appropriately planned. We were provided with electronic copies from the 'Care Free' system of each staff member's 'bookings list' for the month of October 2016 to 29 November 2016. When we looked at this information it was immediately obvious that staff were unable to achieve some of the visits as they had been double booked or the visits planned were 'back to back' leaving no time for travel in between visits. It was clear from the information provided that the number of visits planned could not be achieved in accordance with what had been commissioned by the Local Authority in support of people's needs as the number of staff employed against what contracted hours were required did not equate.

For example all the staff bookings lists we looked at showed that at various times throughout their shift, staff members were allocated to more than one person's visit at the same time. This meant it was impossible for staff to provide people with the support they needed at the required time or for the length of time needed. It also led to a consistent pattern of late and missed visits.

The provider told us that they had experienced significant staff sickness and staff leaving over the last few months that had impacted on the ability to deliver the service and the care people required. It was clear from our discussions with the provider that they knew people were placed at risk because of this situation.

These examples were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that sufficient number of suitably qualified, competent and experienced staff were deployed to meet people's needs.

The provider had a policy in place for identifying and reporting potential safeguarding incidents.
Staff we spoke with demonstrated an understanding of potential types of abuse and the action to take should abuse be suspected. Not all of the safeguarding issues we identified during our visit or safeguarding incidents identified by the provider prior to our visit had been reported to The Commission in accordance with legal responsibilities.

We found internal action that had been taken to address and mitigate any risks to people's health and welfare although a lack of sufficient staff meant that progress was slow. For example annual reviews of people's care packages to ensure that the number of staff employed could safely meet people needs was not taking place. The new care packages taken on in July, September and October 2016 that equated to over 830 people was slowly being reviewed as some people did not have a care plan in place. In addition, neither the provider nor the registered manager had notified the Care Quality Commission of the risks posed to people's health and wellbeing by taking on the three new contracts from the Local Authority and the risks identified due to staff shortages.

Where people had experienced missed and late calls, these incidences had not been consistently reported to the Local Authority as a serious incident in accordance with the Local Authority contract and local safeguarding procedures. The provider has also failed to notify The Commission in accordance with statutory notification procedures. This meant that procedures in place to protect vulnerable people were not followed by the provider to safeguard people from harm.

These examples were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to protect people from improper treatment, potential neglect and harm.

When we looked at people's care files, we found that the majority of people's needs and risks were not properly assessed, managed or documented. Care records gave staff limited or no guidance on how to meet people's needs and minimise any risks. Care records kept at people's homes were also incomplete and

not regularly reviewed.

For example, one person was identified by the Local Authority as living with a specific health condition. This health condition predisposed the person to an eating disorder. Despite this, no assessment of the person's condition or any associated risks had been considered in relation to the delivery of the service by the provider. There was no information in the person's care plan about the signs for staff to spot should the person's health decline or guidance on how to provide safe and appropriate care. The person had lost 10lb in weight and weighed 5 stone and this should have initiated a review and the service should have liaised with other health professionals to support the person.

Another person had numerous health issues and we saw from the sparse information at the office and the person's own home that staff were not informed of what actions to take as the person's care plan made no reference to the person's recently broken arm and how this impacted on their day to day living.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that risks in relation to people's care were adequately managed.

We checked a sample of people's Medication Administration Records (MAR). We found unexplained gaps in people's MAR are which had not been investigated by the provider. This meant that we could not verify if the medicines had been administered. We were unable to determine whether this was a recording issue or whether the dose had been missed because regular medication checks of people's medication had not been completed by the provider or registered manager. The compliance manager and the registered manager told us that they were aware that medication reviews were not being completed and were aware there were issues for people receiving medication administration support.

People's daily logs and other documentation provided showed that their medications were not prompted or administered at consistent times due to the irregularity of people's visit times. There was also no information in people's care files with regards to the time their medication should be taken. In addition, the daily logs for some people did not show that their medication prompts had been consistently given by staff. This meant it was unclear as to whether the person had been prompted by staff to take their medication or not.

For example, one person's daily logs showed that visits were missed and the person did not have a MAR. We saw that the person was on a lot of medicines including Morphine patches and liquid morphine medication. The care plan stated in one place 'independent' with medication and also stated the person had their medication in a blister pack. The medication was not in a blister pack. The person told us that they had falls "because of my meds" and also said "I have a broken arm; the carers help me to do it. They pour it out for me, I can't get the lid off the, it's a child proof bottle". There was no record of how much Morphine medication had been taken. This meant that the provider could not be sure that the person had taken their required medication. There was no evidence that the person's GP or social worker had been contacted to discuss this.

Another person was prescribed time specific medication and an assessment record we looked at informed 'All medication must be given at correct time as they are time critical due to their illness'. We looked at records for this person including actual visit times and found that some visits were missed and a lot of visits were late.

Medication risk assessments and assessments of people's ability to administer their own medication were

completed but they had not been regularly reviewed to ensure any medication risks were appropriately managed. We also found that information provided to staff in relation people's medication was inconsistent. For example, one person's care plan stated staff were to just prompt the person to take their medication but there was a MAR in the person's home signed by staff to indicate staff had full responsibility for administering the person's medication on a daily basis. In some care files, the person was indicated as self-medicating yet their daily logs clearly indicated that staff were involved in the administration process but a MAR was not in their home for staff to complete.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that people received the medication they needed and at the required time.

During our visit we asked the provider to make safeguarding referrals to the Local Authority with regards to the people whose care we had looked at.

We looked at six staff files that were chosen at random. The information for three staff who had transferred over to the service was sparse. We were informed by the registered manager that the staff files were in a mess and required auditing and that his had not taken place due to staff focusing on getting care plans written.

We requested the Disclosure and Barring Service (DBS) checks information of all staff from the registered manager. This information was handed back to the registered manager twice because the information provided was incorrect. The provider told us that they were in the process of checking the DBS of all staff that had transferred over from the new contracts. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have.

Inadequate

Is the service effective?

Our findings

Some of the people whose care files we looked at required support with meal preparation to ensure that they received adequate nutrition and hydration. When we looked at people's daily logs and at the actual time documents provided we found that people did not always receive the support they required when they needed it due to missed or late visits.

For example, we saw that one person's visit was late on ten occasions from October 2016 to 24 November 2016. Also there were missed visits and actual time reductions for the meal preparation from staff. Records at the home of the person informed that staff had not provided or made the meal required on a number of occasions.

Some people receiving care and support from the service had mental health issues that may have impacted on their ability to make informed decisions about their care. We saw that one person's care file indicated that they lived with mental health issues. We did not see any evidence in either person's file that their capacity had been assessed or discussed with the person and any significant others involved in their care. There were also no mental health care plan or risk assessment in place to guide staff how to support the person with their mental health needs and any associated risks.

We saw that the person had regularly informed staff who went to their home to support the person with a main meal that they (the person) had eaten. Clearly due to records looked at and talking to the person this was not the case. There was no evidence that the provider had talked to the person about this or assessed the person's capacity to understand the implications of their actions.

A relative we spoke with told us that the only hot meal the person received each day was prepared by staff. They said that call times varied significantly and were often late and had at times recently not turned up. This relative told us that their relative was not able to prepare their own meals due to their mobility.

On looking at people's care plans, we found that people's dietary needs and risks had not been assessed which meant that staff had no clear guidance on how to meet people's nutrition and hydration needs. For example, one person whose care file we looked at lived with diabetes. Despite this no diabetic risk assessment had been undertaken and there was no guidance for staff to follow when preparing the person's meals. There was no information on potential diabetic complications for example if the person experienced a hyperglycaemic or hypoglycaemic attack (high and low blood glucose levels) or the action staff should take if such an attack occurred.

These examples were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure people's nutritional needs and hydration were met.

We spoke with twelve care staff members, seven of whom who had transferred over from other services. They said they had received adequate training from their previous employer but nothing from Premier Care

Wirral. Staff told us they did require updated mandatory training for example for Moving and Handling. We did not receive a staff training record as the provider told us this was still being collated as the service did not have the relevant training records for staff taken over in new contracts so were not aware of what staff had completed and when. The staff records we reviewed however did not have a lot of detail in place.

We discussed the provider's training schedule and when it would be implemented to identify the training needs of each member of staff and the date they had last completed the training required to ensure they were competent in their roles. We were told that it was proving to be very difficult as a lot of staff transferred from the previous employers who had not sent over relevant training records as required.

There had been a new induction training programme provided to new staff that had been recently recruited; the training manager had implemented an induction programme that was being rolled out every two weeks. The issue was we were told was that staff were completing the 'Care Certificate 'records that were a ten week programme that should be checked to ensure staff were competent in their roles. The training manager told us that she had not been monitoring the records herself as she was told the registered manager was doing this. We were told by the registered manager and the provider this was not the case and a new monitoring system would be implemented to ensure staff competency. The Care Certificate is a set of standards that social care and health workers should use in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

The training manager told us that she had been offering and providing mandatory training in a range of subjects including; health and safety, moving and handling and safeguarding. This was offered two days a week to staff, however there was no system for her to look at to inform who should be attending this refresher training.

We saw evidence that new staff members recruited had received an induction into their job role, but not those taken over from other providers. There was little evidence that staff had received adequate supervision or had an appraisal of their skills and abilities. We asked the provider for evidence of both. We were told that there was currently no staff receiving supervision or an appraisal due to the pressures of senior staff implementing care plans in the community. We were told that there was only staff monitoring for supervision if there were competency or disciplinary issues.

None of the staff files we looked at contained any evidence that the skills and abilities of the staff member had been evaluated. The majority of staff we spoke with said they had not had an appraisal or couldn't remember one being undertaken.

These examples indicate staff did not have sufficient support to ensure they were delivering care safely and to an appropriate standard to the people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

During our inspection, we found that people's experiences of care were affected in a negative way by the lack of sufficient staff to meet their needs and by the way that the management responded to concerns about their care.

We asked the people we spoke with if anyone called them from Premier Care Wirral when a visit was going to be late or missed. People told us that no calls were received. This meant that people who used the service did not know if the support they needed would be provided. One person told us "I don't know what to do when carers don't turn up". Another said "The new company is terrible, I am always calling because they are late and have missed my visits" and other people told us that staff providing support did not stay very long as they were always rushing.

Two people we spoke with indicated that the management team did not respond to their concerns about their care in a caring or meaningful way. One person told us that they believed the management team were not always honest about the whereabouts of staff when they were late. They said they were told "The carers are on their way" when they clearly were not. Another said that when staff were late they got told staff were "On their way" but it could be hours before anyone turned up. This demonstrated that people were not always given appropriate explanations for why their planned care was not provided as agreed or preferred.

One person told us they had informed the office that they had an important hospital appointment and wanted their care earlier on the morning of the appointment as they were unable to do their own personal care. The person attempted to call three times and was told the carer was on their way. In fact the carer was on a day off and no carer was sent. The individual went to the hospital appointment in their night clothes, this impacted on their dignity.

A relative we spoke with told us that they had asked for staff to ring them if they couldn't gain access to the person's home due to concerns about the person's safety but they never had.
It was clear that the provider had not taken any effective action to address people's comments as the similar feedback was made by the people we spoke with during and after our visit.

These examples were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to make every reasonable effort to meet people's preference or take any action to respond to people's concerns about their care and people's dignity was not always respected

When we asked people about the staff that visited them. Most comments made were positive. They said that the staff who visited them were "lovely" and treated them kindly. People's comments included; "The staff are really good but so busy". Another, "They're all lovely, they just haven't got enough staff", and "They are very willing to help but don't have the time". "The staff who visit me are nice and do what they can". "They're very caring people". These comments demonstrated that people thought the staff that supported them were kind and compassionate in their approach.

Inadequate

Is the service responsive?

Our findings

During our visit we looked at the care plans for 14 people, 11 in the office and three in people's homes, we also looked at a sample of their daily logs. We found a lack of person centred information in all care records we looked at. Of the 11 looked at in the office, four did not contain any information at all just an empty file. The care plans we saw had little information about any person centred care were not in date and were not fully completed. None of the 14 files looked at identified the person's wishes in relation to how the care should be provided.

Adequate information about people's personal care needs, daily routine, nutrition and hydration; skin breakdown; continence care and moving and handling was not provided in their care file. Information about people's medication was poor and often contradictory. All of the care plans we looked at failed to provide sufficient detail and guidance for staff to follow in the delivery of care.

The majority of care plans we looked at were out of date and had not been reviewed for some time. From the daily logs we saw evidence that people's needs had sometimes changed but due to a lack of care reviews, people's needs had not been reassessed and their care plan amended. This left people at risk of receiving inconsistent or inappropriate care.

This meant that the provider and registered manager had failed to protect people from the risks of unsafe or inappropriate care as an accurate record of their needs, risks and care had not been maintained. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw many examples of people receiving care at irregular times and in some people received two visits close together which often meant breakfast and lunch calls, and lunch and tea time visits were only a short time apart. Visits at irregular times meant that some people did not have their medicines at regular intervals, access to adequate nutrition or hydration at appropriate times and some people waited for long periods for personal care, putting their skin integrity at risk. We found that the daily logs we looked at did not show that people received the care they needed had agreed to in conjunction with the service.

We visited one person and had serious concerns about their welfare. When we spoke to the registered manager about this we found that a deputy manager had visited the person recently and had not picked up any welfare concerns. We also found that the deputy manager had failed to notice that this person did not have an updated care plan that accurately reflected the care they required and advised staff on the person's needs and care. We spoke to the registered manager, compliance manager and the provider about this, and asked them to refer this person to the local authority safeguarding team due to the concerns we had about their health and well-being.

We also had serious concerns about the welfare of another person we visited. The care plan in place did not reflect the care the person required or advise staff of the person's needs and care. There were concerns over the number of visits taking place, missed calls and the person was taking a lot of pain relief medication that was an opiate. The staff records were inconsistent and medication records were not in place. There were no

records to inform of any reviews or updates from the service. We spoke to the registered manager, compliance manager and the provider about this, and asked them to refer this person to the local authority safeguarding team due to the concerns we had about their health and well-being.

These examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to design care which achieved people's preferences and met their needs.

We saw that the provider had a satisfactory complaints policy in place to advise people what to do and who to complain to, should they have concerns about the service or their care. We saw two complaints recorded in the provider's complaints file; these complaints had been responded to inappropriately by the provider. Both complaints should have initiated a safeguarding referral to the local authority as they were in relation to missed visits for both people. We requested both be referred to the local authority safeguarding team due to the concerns. We found evidence that the provider did not always listen or responded to people's complaints or concerns in any meaningful way.

For example, a number of people who used the service told us they had contacted the service in relation to late visits, but there was no evidence the provider had investigated, responded to or resolved these concerns.

Two of the people we spoke with and relatives expressed serious concerns about the quality and reliability of the care received. Both people and the relatives told us they had complained many times to the provider about the quality of the care provided but little had changed. The relative told us that had the person's care plan "was non-existent".

When we discussed the complaints procedure with the registered manager we were told that the system used, known as 'Care Free', had an area for staff to complete if a complaint was raised. We asked how they picked up the complaints from this and were told "We don't unless staff brings it to our attention". We found no evidence that that the provider's complaints policy had been followed.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have an effective system in place to record, handle and respond to people's complaints and where complaints had been received had failed to investigate and take proportionate action.

Inadequate

Is the service well-led?

Our findings

During our inspection, we found that there were no effective systems in place to ensure the health, safety and welfare of people using the service.

The provider told us that the quality and safety of the service had been affected by the amalgamation of three new contracts for care commissioned by Wirral Local Authority from July 2016 to October 2016. This equated to the service now providing a service to over 830 people. At the time of this inspection, staffing levels were still being looked at as the service had gone from having 40 staff to over 430 staff. There were staff shortages as we were told the provider still had over 1000 hours of care not allocated to any carers so that meant they had to allocate daily to care staff. The provider had taken on a huge responsibility to provide care to an unknown quantity of people that was causing risks to people's health and well-being.

When we looked at a printout of actual and planned visit information and compared this to people's daily logs, we were able to easily identify where people received short visit, late and early calls or missed visits. We were also able to easily identify where staff were booked on more than one visit at the same time. It was clear that staff could not achieve the visits they were allocated at the times specified or during their working hours.

We asked the provider if they had looked at the same data as we had. They told us they had and there were anomalies in the system that showed missed visits that were actually cancelled. All the people that we looked at records for we corroborated that there were missed visits. We requested weekly analyses of the visits that were late, missed or unachievable; we did not receive the information to date. In addition there was no evidence any action had been taken to ensure staff were physically able to achieve each of the visits or that the provider had checked staff had actually turned up to support people when they were supposed to.

During our visit, we raised serious concerns with the provider about people's safety. We identified serious concerns about the way people received care and the management of the service as a whole. We were concerned that there were immediate risks to people's health and well-being. We informed the provider of our concerns and asked them to make safeguarding referrals for a number of people in their care.

During our visit, we found that assessment and care planning information was inaccurate, out of date and insufficient. We asked about care plan audits. We were told by the registered manager and provider that they were in the process of reviewing all 830+ people and had completed over 300 care plans in the community. The lack of up to date care plans placed people at risk of inappropriate and unsafe care.

We found there was no system in place to ensure people's care was reviewed regularly. Daily logs of people's care were not reviewed by senior staff to ensure people received the support they needed or to check that people's needs had not changed. Two of the people we visited had care plans that had been implemented in 2016 however were out of date, lacked information and the two people were at risk. This meant there was no effective system in place to check that care plans met people's health, safety and welfare needs.

People's medication administration records (MAR) kept in their own home were not checked regularly to ensure staff had administered and recorded medicines correctly and there were no medication audits in place to check that people received the medicines they needed when they needed them. This meant there were no effective systems in place to check that the actual delivery of care was safe and met people's needs.

The registered manager told us that spot checks on staff were undertaken on a regular basis. Spot checks involved a supervisor observing individual staff delivering care to a person in their own home. This checked whether staff were performing their duties to a good standard. We saw a sample of spot check records that confirmed this had taken place but not recently. There was no evidence however that the findings of the spot check were discussed with the staff member or that the provider analysed the spot checks completed across the company to identify trends or areas for improvement.

The provided did not have an effective staff management system in place that monitored the training, supervision and appraisal of staff. This meant there were no effective management systems in place to ensure staff had the skills, abilities and competencies to provide safe and appropriate care.

The provider had failed to submit statutory notifications in relation to notifiable incidents to The Commission as required by law for example, serious injuries and safeguarding. They also failed to notify The Commission or the Local Authority of the staff shortages that impacted on the delivery of the service and the safety of people in their care.

These examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to have effective systems and processes in place to assess and monitor the quality and safety of the service provided.

The provider told us that they were implementing a quality assurance framework and introducing a new management structure to ensure the service improved to meet the care requirements of people using the service and systems supported staff.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to design care which achieved people's preferences and met their needs.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to make every reasonable effort to meet people's preference or take any action to respond to people's concerns about their care and people's dignity was not always respected

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from improper treatment, potential neglect and harm.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was no suitable system in place to ensure people's nutritional needs and hydration were met.

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system in place to record, handle and respond to people's complaints and where complaints had been received had failed to investigate and take proportionate action.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that sufficient number of suitably qualified, competent and experienced staff were deployed to meet people's needs.