Comfort Call Limited

Comfort Call Stockton

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 December 2015 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. A second day of inspection took place on 8 January 2016, and was announced.

Comfort Call Stockton is a domiciliary care service which provides personal care to people living in the Stockton on Tees area. The offices are situated in a local Extra Care housing complex and near to the North Tees Hospital. At the time of the inspection 148 people used the service. 60 people using the service lived in the Extra Care housing complex that housed the service's office, and the remaining 88 lived at home in the wider community.

The service had a registered manager, but they had recently gone on long-term leave. In their absence, the service was being managed by the registered manager of a nearby service and an area 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.

Care records did not record whether people had consented to their information being disclosed to their emergency contacts. It was not always clear whether people had capacity to consent to their care. Where people had been appointed to make decisions on people's behalf, the service did not retain evidence of their legal power to do so. Care plans did not always contain information people's preferences or how they wanted to be supported. The provider did not mitigate risks relating to the health, safety and welfare of people by making required notifications to the Commission on safeguarding issues. The provider did not maintain an accurate, complete and contemporaneous record in respect of each person using the service. The provider's quality assurance procedures had not identified this issue or led to remedial action.

These were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

We found that the provider had failed to notify the Commission of safeguarding incidents that had occurred in 2015, as the service was required to do.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are taking action in regards to this and will report further once our actions are complete.

People felt safe using the service. Risks to them were fully assessed and care plans were designed to minimise them. Staff understood safeguarding issues, and the service operated procedures to deal with any incidents that occurred.

The service had policies and procedures in place to ensure that medicines were handled safely. However, a record of people's medicines was not kept in people's care plans so we made a recommendation that the service follow the guidance issued by the National Institute of Health and Care Excellence on medicines management and record keeping.

People told us that they received a continuity of care from staff they knew. The service operated recruitment procedures that ensured that only suitable people were employed.

Staff received regular training in the areas they needed to support people effectively. Their performance was monitored and supported through a regular system of supervisions and appraisals.

People were supported to access external health services to ensure their general health and wellbeing.

People and their relatives spoke highly of staff and the care they received.

The service had a policy for dealing with complaints, but we could not see any records of investigation or that outcomes were communicated to people. We have made a recommendation about the management of complaints.

Quality assurance checks were carried out to monitor whether people were happy with the care they received, and people told us they would be happy to raise issues with management.

Staff told us that their views were sought, that management was approachable and that they felt involved in the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported to access and administer their medicines safely.

Risks to people were assessed and care plans were in place to minimise them.

People were supported by staff that had been appropriately recruited and inducted.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not operate effective systems for obtaining people's consent to care.

Staff received suitable training to ensure that they could appropriately support people.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the care they received and described staff as caring and supporting.

Policies were in place to support people to access advocacy services where necessary.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain information on people's preferences or how they wished to be supported. We made a recommendation about recording medicines on care plans.

People knew how to make complaints to the service, but we could not verify that these were acted on. We made a recommendation about seeking advice on the recording and management of complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not always notify the Commission on changes in how it was managed or safeguarding incidents.

People's view on the service they received were sought and people felt confident to raise issues.

Staff felt supported by management and described a positive working culture.

Comfort Call Stockton

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 29 December 2015 and was announced. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. A second day of inspection took place on 8 January 2016, and was announced. A third day of inspection took place on 1 February 2016, and was announced. At the time of the inspection the service was providing personal care to 148 people.

The inspection team consisted of one adult social care inspector.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered 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 contacted the commissioners of the relevant local authorities and clinical commissioning group, and the local authority safeguarding team to gain their views of the service provided by Comfort Call Stockton.

During the inspection we spoke with eight people who used the service, five of whom we visited at home with their permission. We looked at 10 care plans, three Medicine Administration Records (MARs) and handover sheers. We spoke with eight members of staff, including the acting manager, the area manager, and six care staff. We looked at five staff files, which included recruitment records.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "I like it and feel safe. They always look at the plan when they come in." Another said, "I feel safe. There are no worries with them." A relative told us, "[I] have no problems about safety." Another said, "[My relative] is safe with them. They all came and did risk assessments, I was there. They checked [my relative] and the environment. We were all happy."

Risks to people were assessed and used to design care plans that minimised these risks. When people started using the service they were assessed in areas such as falls, skin integrity, nutrition, environment and medicines. Where a risk was identified, this was used to design a care package that minimised the risk. For example, one person was identified as having a high risk of falls and their care plan required staff to offer additional assistance to them when they were moving around their home. In another example, a person was identified as being at risk of self-neglect to personal care. Their care plan specified that the person should be encouraged and reminded about this on a regular basis, and daily records showed that this was happening. Staff told us that they understood the importance of keeping people safe whilst also giving them the freedom to make their own choices. One member of staff said, "I support [a person] who does not always have balance. I put their frame next to them for them to use when they want, and stand next to them when walking and give instructions to reassure [the person]." Another said, "We keep people safe by being on the lookout for things, by risk assessing and by making sure everything is clean and tidy." A third said, "We always look for trip hazards, carpets, wires trailing and things like that. If I saw something I was concerned about I would mention it to [the person] and ask for permission to move it. I would then put it in the log book." This meant that the service monitored risks to people and took steps to minimise them.

The service monitored accidents and incidents to keep people safe. Where an accident occurred details where recorded of who was involved, where it happened and any remedial action taken. This was placed in the person's care record and was also uploaded to the service's computer system. The acting manager said, "We monitor it for any trends and patterns. It is also reviewed by our clinical support managers." The last recorded accident took place in September 2015, and was fully recorded in the person's file and on the computer system. This helped to keep people safe from the risk of accidents.

There was a safeguarding policy in place, and staff had knowledge of possible risks to people. The safeguarding policy described the types of abuse that could occur, descriptions to help staff identify them and guidance on the procedure to be followed when reporting concerns. Where concerns had been raised, records confirmed that investigations had taken place. Staff confirmed that they were familiar with the policy and would be confident to raise any concerns that they had. One said, "We look to see if people are [at risk of] abuse. We check things like bruising, if they are not being looked after or getting food, things like that. If I had any concerns I'd report it straight to the manager and they would investigate." Another said, "If I had any concerns I would ring the office. They'd deal with it straight away."

There was a business continuity plan in place dated 1 October 2015. This contained guidance to staff on dealing with a number of emergency situations, including useful contact details. Arrangements had been made to relocate the office to alternate premises to continue care delivery in emergency situations. This

meant that people would receive appropriate support in emergency situations.

The service operated a recruitment policy that helped to keep people safe. Application forms asked applicants about their skills, qualifications and employment history. Interview notes showed that applicants were then asked about their motivation for working in a care setting and to give examples of how they had challenged poor practice and wrongdoing. References and Disclosure and Barring Service checks were obtained before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helped to minimise the risk of unsuitable people from working with children and vulnerable adults. Staff files contained photographic identification and proof of identity for staff. Staff we spoke with confirmed that checks had been made before they were offered their jobs. One said, "When I was recruited that checked references, proof of identification and DBS checks. They also checked my qualifications." This reduced the risk of people being cared for by unsuitable staff.

People told us that they were supported by a regular team of staff. One person said, "I have my two usual carers now, and they're absolutely brilliant." Another said, "[The care co-ordinator] knows what we want and how we want it. She knows we want a continuity of care. I have a regular [member of staff]." A relative told us, "They have the same two girls all of the time. They do try, when one is off, to always have someone there [my relative] knows. They are generally on time but if there are emergencies and they're running late they always let us know." Another relative said, "We have regular carers that [my relative] has a rapport with." A member of staff said, "There are definitely enough staff and we never have to rush." Another said, "There are definitely enough staff from what I have seen." A third said, "There is enough staff. On some calls you do get travel time, and people are not that far away from each other." The area manager said, "If people's needs increase we increase staffing…Things change all the time so we always keep an eye on staffing. We are almost recruiting on a daily basis as it takes around six weeks to get checks in so we recruit because of the lag time." This meant that the service had procedures in place to ensure that staffing levels matched people's support needs.

The service supported people to access and administer their medicines. One person told us, "They help me with my medicines…it's all written down and they always make sure I have it." A policy was in place which gave guidance to staff on their roles and responsibilities, 'when required' medicines and reporting. Where people were supported with their medicines, medicines administration records (MARs) were used. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We saw evidence to show that MARs contained details of which medicines people had been prescribed and how they should be administered and any allergies the person had. The manager undertook monthly checks of MARs, and we saw that where gaps in record keeping occurred they were identified by the checks and remedial action was taken.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Care plans did not always record whether people had consented to their care or whether they had given others permission to make decisions on their behalf. Each care plan began with a 'contact and personal information sheet' which included details of relatives who were emergency contacts. This was followed by a tick box to record whether the person consented to their information being shared with these contacts. That section was left blank on the care plans we looked at, which meant it was not possible to say whether the person consented to information about them being shared. Care plans sometimes contained contradictory information on whether a person had capacity to consent to care. For example, in one plan a person was recorded as being able to consent to care. Elsewhere in the same plan, it was recorded that the person's relative had a Power of Attorney over their health and welfare which meant that they would consent to treatment on the person's behalf. However, there was no documentary evidence to confirm the Power of Attorney. In another person's care plan they were recorded as having capacity to consent to care. Elsewhere in the same plan there was a judgment confirming that a Deputy had been appointed to manage their affairs in their best interests. This meant that the service was not always ensuring that care was being provided with people's consent, or with the consent of those legally responsible for making such decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received mandatory training in health and safety, food safety, infection control, first aid, medication, moving and handling, safeguarding and dementia awareness. Mandatory training is training the provider thinks is necessary to support people safely. Staff received refresher training in these areas annually. Staff also received additional training in areas such as dignity and respect (including consent and the Mental Capacity Act 2005), record keeping, stroke awareness and continence care. The service used a computer system to monitor staff training. This confirmed that staff training was up-to-date. Staff files contained copies of training certificates to show that training had been completed. These also contained knowledge tests of the module just completed, and asked questions such as, 'list ways in which you can help maintain an individual's independence when they are [living with dementia].' Staff said they received the training they needed to support people. One said, "The training is really good. I had training when I first started and have updates every year. A trainer comes in and does a refresher, and we have a workbook we go through. It covers everything, including medicines, manual handling and safeguarding. I did once request specialist training in end of life care. I just spoke to the office and they put it in place." Another said, "I enjoy the training. There was a week in Middlesbrough before I started, then shadowing. I haven't had refresher training yet but that is coming up." We asked people and their relatives if they thought staff had the training needed to support them. One person said, "They know what they're doing." A relative told us, "I definitely get

the sense that they know what they're doing."

New staff were required to complete induction training before supporting people. This involved completion of a training booklet which tested staff knowledge of policies and procedures and required them to describe the skills needed in different situations.

Supervisions and appraisals were regularly carried out to monitor and support staff performance. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff files contained records of their supervisions and appraisals. Supervisions consisted of office based discussions and 'field based observations' where care delivery was assessed. These showed that as well as being used to test knowledge, staff were also free to raise issues. One member of staff said, "We have supervisions and appraisals all the time…I would be happy to raise any problems." Another said, "I had an appraisal a couple of weeks ago…[we're] asked if we have any problems and I've never had any."

The service worked with external professionals to support people's health and wellbeing. One person's relative told us that the service helped to arrange a visit to their relative by the memory clinic, so that additional support could be put in place. The relative said, "If [my relative] wants something she just tells them. If they have any concerns they ring me." People's daily notes contained details of contacts with professionals such as GPs and district nurses. For example, for one person, we saw that staff had contacted the GP to request changing their medicines. This meant that the service promoted people's access to wider healthcare to assist with their general health and wellbeing.

Good

Is the service caring?

Our findings

People and their relatives told us that they were treated with dignity and respect. One person said, "[Staff] are always polite and respectful." Another said, "You can talk to them and nothing goes any further" and then joked, "They're always very respectful. I wouldn't let them in otherwise." A third person said, "They are lovely when they come here. I look forward to them coming. I make friends with them but they are always professional. They always ask my permission to do things…They treat me with respect." A relative told us, "They are spot on with dignity and respect."

We asked staff how they maintained people's dignity and treated them with respect. One said, "We make sure that people are covered up [when giving personal care] and always ask people if they want help. It's about how you speak to people. You never speak about people in front of them. You take time to sit down and speak to them. Even if they don't need anything I like to talk to them." Another said, "You never talk over people…You get to know people as there is a lot they can tell you." A third added, "Privacy is very important." Another said, "You always ask people what they would like, close doors if in the shower, close blinds and cover them up."

Staff told us how they helped to promote people's independence. One said, "I always get people to try to do things first. I always check care plans to see what people can do and try to get them to do it…we want people to be independent." A person we spoke with said, "I cancelled some calls as I wanted to go out and they changed [the calls]. I wanted to do things for myself so they changed [the calls]."

People and their relatives told us that staff were caring. One person said, "Things are absolutely fantastic… everything is amazing. They look after me… They help me to keep my independence. I am insistent on doing things myself…and they let me…The care is absolutely second to none." Another said, "They're very good and very nice." Another said, "Care staff do a good job. They look after me and are good people. " A fourth person said, "I love them all to bits. All the carers I've had have been brilliant." Another person added, "The carers are very good to me. I have no complaints. They do things that I want." A relative told us, "The [staff] are really good and friendly. They don't hurry [people]." Another said, "They are brilliant with [our relative]". Another said, "[Our relative] has regular carers that they have a rapport with."

We asked staff how they delivered care. One said, "I would like to think the care I give is the care I would like to receive. I always try to put people at their ease." Another said, "I always have time to talk to people, either after I am finished or when doing jobs." They then went on to describe to us how they had worked with the person's relative to help reassure the person that they did not have to feel embarrassed about receiving personal care.

At the time of the inspection no-one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The service user guide given to people when they started using the service contained information on advocacy services, and the manager explained that this could be arranged for people who wished to have one.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always contain detail on what was important to people and how they wished to be supported. Some care plans contained detail of people's needs and preferences which would allow person-centred planning of care. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. For example, one person's plan explained that they sometimes liked to have breakfast in the local bistro but that if they changed their mind they would like staff to help prepare it for them at home.

However, care plans were not completed to this consistent level of detail. Some care plans began with a life history of the person, but others were missing this information. Each care plan had general outcomes that the person wished to achieve listed, but these were often generic, standardised goals such as, "I would like support to maintain a clean, safe environment." This was often followed by another general statement, such as, "Care staff support me with attending to my domestic tasks on a weekly basis" without any further detail on how the person wanted support to do this. In one person's care plan, their stated goals included having a balanced diet and participating in social activities. There was no information on the person's dietary preferences or social interests listed in the care plan, or any evidence of how this was being done in the person's daily notes. In another person's plan, it was recorded that they wanted, 'support…with showering and support me getting dressed.' There was no information on what the person wished to do for themselves and the level of support they wanted. This meant that staff working from the care plan would not have known what was important to the person and how they wished to be supported. In another person's plan, there was a reminder to staff to ensure that the person was wearing their pendant alarm before staff left. This was written in bold and highlighted in the care plan. There was no record in the care plans that this check had was being carried out, which meant the person may not have been receiving support that reflected their preferences.

We asked staff how they knew what was important to people and how they wished to be supported. One said, "You get to know their preferences from the care plan." Another said, "We have a handover book that keeps us up to date. We always read that book." We saw that people's preferences for their care were not always recorded in care plans or daily notes, which meant staff working from them, would not have known what was important to the person and how they wished to be supported.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that care plans did not contain details of the purpose of, and information on, medicines, the importance of dosage and timing, and implications of non-adherence and details of who to contact in the case of any concerns.

We recommended that the service follow guidance issued by the National Institute of Health and Care Excellence on medicines management and record keeping.

The service had a complaints policy, which people received in their 'service user guide. This contained a definition of what constituted a complaint, which included, 'anything that indicates that someone wants us to do something better', and how the complaint would be investigated. We were given a log that showed that 9 complaints had been logged in 2015. When we asked to see records of investigation of these complaints we were told that they were stored on the service's computer system. The acting manager attempted to access these, but the records were blank. The area manager told us that complaints were investigated and that outcomes were entered on the system, but we could not check this as there were no records on the system. People told us they would be confident to raise any complaints they had. One said, "If I had any concerns I would speak to the manager. They're always on the phone if I want them." Another person said, "If I had any issues I would go straight to the office."

We recommend that the service seek advice and guidance from a reputable source, about the recording and management of complaints.

Requires Improvement

Is the service well-led?

Our findings

During the inspection, we saw that the service had not notified us about safeguarding incidents that occurred in 2015. These included medicine errors that resulted in disciplinary action against staff, and omissions in care documentation that had been substantiated following safeguarding investigations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are taking action in relation to this breach and will report on this further once our actions are complete.

We were told that care plans were reviewed by senior care staff if people's needs changed or, as a minimum, every 12 months. However, these checks had not identified any of the issues we identified during the course of the inspection in relation to care plans not detailing people's preferences or recording how consent had been obtained. There was also a delay in the service providing us with the outcomes of some of the safeguarding incidents in 2015 as this had not been recorded at the branch.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff to describe the culture and values of the service. One said, "Lovely to work for. Just so approachable." Another said, "Lovely people and clients. A nice, happy place to work." A third said, "A very good company to work for. Any time I do something good they're always on the phone to say so. They're really good."

The acting manager told us, "We do quality assurance visits to people every three months. Usually it's three actual visits and one telephone check. There's also an annual survey from head office, which allows people to give anonymous feedback. The seniors do quality assurance visits and if there's anything needing to be actioned they follow it up. After it has been carried out, we put it on [the computer system] and that tells us whether it has been done." Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The quality assurance visits asked people a serious of questions about how staff treated them, whether they were content with the care they received and their views on the overall quality of the service. Care plans we looked at contained copies of completed 'quality assurance visit records'. For example, one completed on 7 December 2015 recorded that the person had no missed calls and that staff encouraged them to maintain their independence.

People and their relatives told us their views were sought on how the service was run. One person said, "They always ask how things are going. A girl in the office comes every month, I think." Another said, "If I ever wanted anything changing I would just have to speak to the manager." A third said, "They ask if you are alright." Another person told us, "They do a questionnaire to see if we're happy. I had [the care co-ordinator] in the other day to do a survey. I think they're every six months. I think they do alright for me. If anything is bugging me it gets sorted out straight away. I can go to the office straight away." Another person said, "They come around now and again - the senior carers - with forms and ask you questions. I would be happy to complain. The seniors come around and do regular checks." A relative said, "We did a feedback survey a few

weeks ago. Every month we have a meeting with them…to review. If there is anything we're unhappy with we'd discuss it."

The acting manager told us that the results of surveys were also reviewed by the provider, and that support was put in place if actions were needed. They said, "If there's a problem the branch would be given an action plan to put things right. If a specific person gives their name [on feedback] we would do an individual quality assurance questionnaire for them. The branch manager then follows this up." The area manager confirmed this, and said, "We have quality teams that do an audit every year...All compliance [checks] go on our [computer system] and we monitor that at provider level. I do one to one meetings with branch managers, and we do branch manager team meetings." The area manager also explained that other support was available to the service. They said, "There is lots of support, not just me. A director [of the provider company] is local and helps. We have human resources support, from South Shields, to help employees. The human resources manager goes around all of the branches and helps." A person we spoke with told us that a director from the provider company had visited them and asked for feedback.

Staff told us that they were supported in their roles and encouraged to give feedback on how the service could be improved. One said, "Management are lovely. We have staff meetings every 2-3 months and go through things like uniforms, reporting and reminders of policies. You can raise things in meetings but you can always just go to the office if you have a problem. We're asked for our feedback in individual people and how they're getting on." Another said, "I feel supported by managers…I would be comfortable raising any issues and I think they'd act. They're good at what they do and are supportive." A third said, "They've phoned me loads of times to see how well I'm doing, which makes me feel supported. I don't have any problems phoning if I need anything."

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 Care plans did not always contain information people's preferences or how they wanted to be supported. Regulation 9(1).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care records did not record whether people had consented to their information being disclosed to their emergency contacts. It was not always clear whether people had capacity to consent to their care. Where people had been appointed to make decisions on people's behalf, the service did not retain evidence of their legal power to do so. Regulation 11(1) and (3).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not mitigate risks relating to the health, safety and welfare of people by making required notifications to the Commission on safeguarding issues. The provider's did not maintain an accurate, complete and contemporaneous record in respect of each person using the service. The provider's quality assurance procedures had not identified this issue or led to remedial action. Regulation 17(2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Commission had not been notified of safeguarding incidents that occurred in 2015. Regulation 18(2)(e).

The enforcement action we took:

We dealt with this breach outside of the enforcement process by issuing a fixed penalty notice.