Comfort Call Limited

Comfort Call Sunnyfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 September 2016 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care and we needed to be sure that someone would be at the office.

Comfort Call Sunnyfield provided domiciliary care services to older people, who maybe living with dementia, physical disability or visual impairment. This care was provided to people living in an extra care facility (extra care allows people to continue living independently, while offering onsite care and support if required over a 24 hour period). The building was managed by Housing 21 and care provided by Comfort Call Sunnyfield both based at the service. There were 71 people who were currently residing at Comfort Call Sunnyfield. Only 34 people were receiving personal care.

This was the first inspection since the service registered on 26 February 2015.

There was someone currently carrying out the manager role in the registered manager's absence. However following the inspection visit the registered manager cancelled their registration during October 2016. 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.

People using the service and relatives told us they felt safe. Care workers we spoke with understood their responsibility in protecting people from the risk of harm and told us they had undertaken a range of training, to support them in their role. People told us that care workers treated them in a caring way and respected their privacy and supported them to maintain their dignity.

However, we found that the leadership and management of the service and its governance systems were not robust. Systems to monitor and review the quality of some areas of the service people received, were not in place and therefore we found a number of areas that required improvement.

People's health and wellbeing was not always maintained. For example, care workers were not always aware of people's health conditions and the treatment to support them. People who were supported with their medicines were not always protected against the risks associated with poor medicines management. People did not receive personalised care which met their individual needs. Care plans had not been updated to reflect the changes in people's needs and risk assessments did not provide care workers with detailed guidance on how to mitigate risk.

The provider did not have effective procedures for care workers to follow in relation to the Mental Capacity Act 2005. Care staff were not clear about people's individual capacity to make decisions.

Care workers told us they did not feel supported due to the lack of consistency in the management at the service. Complaints were not well managed. People felt issues were not resolved satisfactorily. A relative told us they had made a complaint however they had not received an outcome.

People felt there were not enough care workers on duty or on the premises during the night to ensure their safety. Recruitment procedures were not thorough. Staff recruitment records showed that a full employment history was not always in place.

We found breaches 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive their medicines as prescribed or safely. The deployment of care workers was not always effective and care was not always provided at the agreed times and in a consistent way. Recruitment procedures were not thorough to ensure risks to people's safety was minimised. People told us they felt safe. Care workers knew how to recognise and report potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers felt they were not provided with sufficient support, due to the lack of continuity in support from management. Effective procedures were not in place in how to protect the rights of people who needed support to make decisions and consent to their care. People were not always supported to maintain their nutrition. People's health needs were not always monitored by staff to ensure their health and well-being.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their representatives were not always involved in making decisions about their care. People were not always supported by care workers that were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always effective.

People were not always involved in planning their care. Care plans did not provide clear guidance for care workers about how to provide care to meet people's needs in the way they required and preferred. People did not receive individualised care. People were not confident that any concerns they raised would be listened to and action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Following the inspection visit there was no registered manager in post from October 2016. There was lack of leadership and consistency in the day to day management of the service. The provider's governance and quality assurance systems were not effective in determining the quality of the service provided and developing plans to bring about improvement.

Comfort Call Sunnyfield

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 was 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 visit took place on 13 September 2016 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 available at the office. On day one the inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second expert-by-experience did not attend the agency's office, but spoke by telephone with people who used the service. The telephone interviews took place on 15 September 2016.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We also spoke with the local authority that provided us with current monitoring information. We used all of this to plan our inspection.

Before the inspection visit, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with ten people who used the service, two people's relatives, and nine care workers. We spent time observing care and support in the communal areas. We observed how care workers interacted with people who used the service. We also spoke with the regional manager and the registered manager from another service within the same provider group who was providing management support at Comfort Call Sunnyfield. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for four people to see if the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and three staff files.

Requires Improvement

Is the service safe?

Our findings

People we spoke with had mixed experiences with regard to the support they received to take their medicines. Some people raised concerns about medicines not being administered safely. For example one person stated they had to remind a care worker on one occasion as they had not been given the correct dose.. Another person told us due to their medical condition they required their medicines at a specific time. This person said the care worker was not always on time, which meant they had to on occasion look for a care worker to support them to receive their medicines. Another person said, "A couple of care workers turn up late, I worry as this means I get my medicines late which impacts on my next dose."

Prior to this inspection visit we received concerns regarding the management of medicines. Information received suggested that care workers were not always administering medicines safely. For example we were told a care worker had administered ear drops into a person's eye and the person required medical intervention. We had also received a couple of notifications from the service regarding medicine errors, such as a person receiving the incorrect dose of their prescribed medicine. A medicine audit was completed by the local authority during July 2016. Issues included care records not detailing the actual support people required with their medicines and medication administration records (MARs) supplied by the community pharmacist were not being used. The care workers were handwriting their own MARs onto Comfort Call records, these were not all signed by two care workers to confirm accuracy. Following the inspection visit we contacted the local authority who confirmed they continued to receive medicine error reports from the provider such as missed signatures on the MARs. As a result of this the health and safety officer from the local authority, revisited the service on 4 October 2016. They recommended that the manager and senior care worker's attend medicines training, guidance on medicines management was given to the manager and to reduce errors with the MARs they had arranged for medicines to be ordered from one community pharmacy.

We looked at three people's MARs and found these were not always completed accurately. There were missing signatures on MARs and the use of codes was not always clear. For example 'A' was used when medicine was declined. However we saw on several occasions care workers had inserted a dot but had not inserted a reason for this. When we asked the managers what this code was used for, we were not provided with an explanation. This showed that the provider could not be assured that people received their medicines as prescribed.

Medicine risk assessments were completed for people which contained information detailing, where their medicines were stored and if medicines were time critical. However they did not describe the actual support people required to manage their medicines. For example one person's risk assessment stated, "Carers to support [Name] by preparing and witnessing medication." We were told a person had not been given medicines as prescribed by the GP, subsequently the person required medical intervention. Another person's care plan recorded that they experienced a 'red rash' and needed topical medicines. There was no guidance or body map to indicate the affected areas and where or how topical medicines should be applied.

The provider told us as result of the concerns around medicines management they had introduced a new

system to improve care worker awareness and competence in supporting people to manage their medicines. This involved care workers completing the provider's training called 'consequence and impact' and evaluating their knowledge and skills. Training focussed on raising care worker awareness of common medicine errors and best practice. A care worker who we spoke with told us the training had had little impact on their working practices. Whilst other care workers felt the medicines training needed to be more in depth. For example, one care worker said, "It would be helpful to know what medicines people are taking and why." All the care workers we spoke with told us they had undertaken medication training and records we looked at confirmed this. This did not provide assurance that care workers were competent in supporting people safely to take their prescribed medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Risks to people through their specific health conditions and their environment had been assessed. However we found that assessments did not include detailed guidance for care staff on how to minimise the risks to people's health. For example, one care plan recorded that the person needed extra support on a 'bad day'. However, there was no guidance as to what a bad day looked like for the person to enable care workers to provide the additional support to keep the person safe.

The regional manager told us there were seven care workers on duty to provide care to people on each morning shift, five care workers on the afternoon/evening shift and one care worker during the night. The night care worker was supported by another care worker who was on call and contactable by telephone.

People using the service and care workers we spoke with, felt staffing levels were not safe at night. Some people felt there were not enough care workers on shift during the night to attend to emergencies. People, who required a hoist to get out of bed, told us they were worried if they had to get out of bed at night. They said this would not be possible as there was only one care worker on duty and they would not be able to use the hoist. One relative said, "I am concerned if [Name] needed to use the toilet in the night there is only one care worker on shift and [Name] requires the assistance of two care workers." Comments from care workers included, "It's not safe to have one care worker working as there are people here who need the support of two care workers" and "Maybe there needs to be a second care worker on site doing a sleeping shift, so that they could respond quicker in an event of an emergency. We discussed this with the regional manager who told us staffing levels were commissioned by the local authority. The local authority confirmed staffing levels in place were reflective of the actual support people required and that staffing levels at night were being monitored on an ongoing basis .

People we spoke with told us they felt safe during the day at Comfort Care Sunnyfield. One person said, "If you want something all you have to do is ring your pendant". Another person told us, "My care worker encourages me to do what I can for myself as long as I am safe." Another person stated, "I feel very safe with my care workers." People said they felt safe in their flats and had no concerns about risks to their possessions when visited by staff. A person said, "I have everything I need when [name of member of staff] leaves me."

People told us pendant calls were answered in a timely way, but sometimes they had to wait for someone to come to assist them. This was accepted by some of the people as inevitable as they felt care workers were very busy. One person gave us an example where they had fallen and were able to summon assistance by using their call pendant. They told us the care worker had attended to them promptly and called emergency services to check if they had sustained any injuries. One relative said, "Staff response to pendant call was good." However one person said, sometimes they didn't get to the toilet in time. Most people stated that the

care workers arrived on time and if they were running late they usually called them to let them know. The regional manager told us a designated care worker was on shift, who responded to pendant calls in a timely manner.

Care workers provided mixed feedback on the staff team and told us a senior care workers were not always on shift. We were told the 'pendant run' (this is where people alerted care workers when they required assistance and a designated member of the care team responded),was not always covered, as the senior care worker was required to cover calls if they were short staffed. Care workers told us on a regularly basis they were short staffed, which was worse during the weekend. They told us morale amongst care workers was low. One care worker said, "Some of the care workers are not reliable, which means other care workers need to fit in additional calls on their run. Or the senior care worker tries to cover the shift." Another care worker said, "Staffing levels look okay on the rota but we could do with more casual staff to cover at short notice. It's a nightmare if anyone rings in sick, which happens a lot. We don't use agency so staff get called in and asked to cover even when they are on annual leave themselves. We work a lot of double shifts which means we are tired." This demonstrated staffing levels were not always sufficient to ensure people were supported safely.

Most of the care workers we spoke with told us they had received training in protecting people from abuse and records confirmed this. Care workers were able to tell us the procedure they needed to follow if they suspected abuse was taking place. One carer worker said, "If I had any concerns I would speak with the manager, or the regional manager." Another care worker stated, "If there were any concerns I would raise these with my manager. I am aware that I can also contact the safeguard team or the Care Quality Commission." Care workers told us they were aware of the whistle blowing policy (informs staff of the actions they should take if they had concerns about the welfare of any of the people who used the service).

We spoke with care workers who confirmed the necessary pre-employment checks had been completed before they commenced working on their own. We looked at three recruitment files to check that safe recruitment procedures were in operation to ensure people were cared for by staff of good character. We found the provider had carried out Disclosure and Barring Service (DBS) checks. The DBS is a national agency that keeps records of criminal convictions. However, we found the provider was not always undertaking thorough recruitment checks to ensure staff were safe to work with the people who used the service. We found one member of care staff did not have a full employment history in place.

Requires Improvement

Is the service effective?

Our findings

The majority of the people told us they felt the care workers were competent at what they did. One person said "I appreciate everything they [care workers] do for me; I get everything I ask for." Another person told us, "The care workers are well trained." However a relative told us, "I don't feel care workers are trained enough." Another relative said, "The care workers are nice, but they don't seem to get training or support."

We received mixed feedback from care workers on the training they had undertaken. A care worker said, "The training provided was good." Whilst other care workers felt the training did not fully equip them to do the job effectively. One care worker told us, the training needs to be more detailed, as we only touched on the different topics. Another care worker also felt the training lacked detail. They said, "I learnt more on the job and picked up things as I worked with people."

The regional manager told us the induction process for new care worker, included shadowing experienced care workers and training. This was so that care workers were able to understand the routines of the service and their expected duties as well as getting to know people. The induction period also included five days where care staff undertook training in a range of area's records we looked at showed this. Care workers confirmed their induction involved shadowing experienced care workers to observe practices and to be introduced to people. One of care worker told us they felt the induction was good and another care worker said, "I learnt a lot via shadowing shifts."

The management team told us formal supervision (a meeting with a manager to discuss any issues and receive feedback on a carer workers performance) took place quarterly. Care workers told us they had received supervision, although the frequency of this varied between individual staff." We discussed this with the regional manager who told us there had been some changes in management and they hoped to resolve this with having a new manager at the service.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA. One person told us the care workers explained what they were doing and involved them in discussions about their care. Care workers we spoke with, were aware of the importance of seeking consent and respecting people's rights. One care worker said, "I always seek consent from the person before I start doing any task." Another care worker told us if a person refused care and they were not able to encourage the person to accept care, they would report this to the senior care worker or the manager on duty or when they were next available. However one care worker was not clear on how they would support a person to make decisions or to seek their consent, they told us they would contact emergency services for advice.

We found the provider did not have effective arrangements in place to ensure care workers knew what to do when people were unable to give to make an informed decision a well consenting to the support they received People's ability to consent to their care and treatment was not always clear. For example, one person's care plan recorded that they were not able to verbalise their consent. However, the care plan did not provide information on how the person was able to give their consent through non-verbal communication and what this looked like. On another person's care plan, it stated, "I can be a little forgetful" and "Get confused at times." There was no information on how the person was to be supported.

Prior to the inspection visit we received information from the local safeguarding team, that care staff had not escalated their concerns regarding a person who had been refusing their meals for a number of days. This person was admitted to hospital due to other health conditions. Care plans in place did not show what help and support people needed to prepare and eat meals or any food preferences they had. A care worker told us they supported a person who was at risk of poor nutrition. They made sure they sat with the person whilst they ate their meal who would often hide their food and throw it away. They also told us the person's main meal had been moved to a lunchtime after discussion with family members as they noticed the person wasn't eating later as they were too tired. When we asked if this was common practice with all care workers, they told us this was not the practice nor written in the care plan. This meant people were at risk of not receiving sufficient nutrition or hydration to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

People using the service and relatives we spoke with, said most of the care workers were respectful, kind and caring. People told us the care provided was respectful and intimate care was provided by care workers of the gender of their choice. Comments included, "I am treated with the utmost respect at all times" and "All the care workers are really kind to me." Care workers told us they introduced themselves, checked with the person what they would like to be called and addressed them properly.

One person was very complimentary about the caring attitude of the care workers, they felt they were treated very well and care workers were always respectful and treated them with dignity. Another person said, "Most of the care workers are caring and spend time to ask me how I am and if they can do anything else for me. They seem to genuinely care about me." However, a relative felt the care workers were not always thoughtful and they were concerned that their family member may develop pressure sores. They said, "I don't think they always think about the comfort of [Name]. Another person told us on one occasion they had called for assistance using their pendant and wanted a female care worker to assist them. However they said the care worker did not pass the message onto other care workers and nobody came. They had to call for support again. We discussed these concerns with the regional manager who told us they were aware of some of these issues and reassured us that action would be taken to address the issues raised.

Care workers we spoke with were able to tell us how they cared for people in a dignified way. They were able to describe how they respected people's privacy and dignity when providing personal care to people. For example, they told us that they would always cover people when carrying out personal care, ensure doors were closed and curtains drawn. Care workers understood the importance of promoting people's independence and enabling them to maintain or develop activities of daily living. One care worker told us, "I enjoy my job here. I treat everyone like my family members, with respect and care." Another care worker said, "I always ask before doing anything, I wouldn't take over." Our observation of care worker interaction with people showed they were caring and helpful. People appeared comfortable with the care workers that supported them. This demonstrated care workers treated people in a dignified manner, respecting their privacy and dignity.

Some people we spoke with were unable to recall whether or not they had been involved in the development of their care and support plan. However, they felt the care workers did respond to their needs and offered personalised and respectful care. One person told us they had fallen out of their chair and felt the care worker responded well and had contacted the emergency services. Care plans and assessments we looked at did not contain information about people's views, wishes and choices.

Some people we spoke with felt that care workers were not consistently caring. They told us they were not always supported by care workers in a timely manner. This included support with their personal care needs and not receiving their medicines on time. One person said, "A couple of care workers are not so good and never really talk to me. They often turn up late and never apologise for this or ring me to tell me they are running late."

Requires Improvement

Is the service responsive?

Our findings

We found the provider was not always responsive to meet people's needs. Some people told us the support received from care workers was not always reliable and they were not always given call times or the duration of calls. One person told us, "I am really unhappy with the poor timekeeping of some carer workers but I don't know what to do about it. We are all under one roof here and I don't want things to get awkward or get people into trouble. I don't know who the managers are and wouldn't know who to go to get it sorted out."

We looked at daily care records, where care workers recorded the time they arrived and left. We saw that people did not always receive care in line with their preferred call times. For example, one person told us some care workers were regularly late for their call. The person's call time was recorded as 9.00am. Call records showed that care workers had arrived at time ranging from 9.15am – 10.00am. We discussed this with the regional manager, who told us they would look in to this ensuring people received calls on time. This meant that people did not receive person centred care.

People we spoke with told us they did not recall been given a rota of which care worker would be visiting them. Most people told us whilst they didn't know in advance who their care worker would be they did generally have regular care workers. One person said, "I have the same care worker each day."

Care plans were not always person centred. Care records we looked at were task focussed and provided little information about how the person preferred to be supported. For instance, one care plan recorded that the person needed assistance to have a shower but did not provide guidance as to how the person was to be supported or what they liked to have around them. There was little or no information on people's preferences or choices in the care records we looked at.

Care records did not include sufficient guidance to enable care workers to provide effective care or information specific to the person. For example, one person was described as having had "A very big stroke". The plan did not detail what impact this had had on the person's health and well-being and what, if any additional support they needed as a result of the stroke. One care worker said, "We don't always have enough information regarding people's needs, such as the level of support they need. If the person has capacity I ask them what support they require or I will ask the senior carer." Another care worker told us, "The care plans and risk assessments do not contain enough information such as whether a person had any allergies." Another care worker told us they understood how to meet people's needs by reading the care plans which contained all the information they needed. However, when we asked how they knew how a person liked to be supported, for example in the shower, they told us they asked the person. They also told us they learnt as they went along.

We spoke with care workers and the information they provided did not reflect what was in another person's care plan. We looked at the person's daily care record where it was recorded that the person was in receipt of end of life care, (support for people who are in the last months or years of their life). They had been prescribed medicines to help them to manage their pain. We saw that the person regularly declined meals and pain relief medicines. According to care workers the person's needs had changed, but this was not

reflected in their care plan which had not been updated. There was no evidence that care workers had responded to look at why the person was declining their medicine or identified any alternative actions that could effectively support the person. This did not provide assurance people received personalised care which met their individual needs.

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

The provider had a complaints policy and procedure in place , but most people we spoke with were not aware of the provider's complaints policy nor did they feel confident that their concerns would be acted upon. One person said they did not know who they should complain to if they had any concerns. A relative said, "I made a complaint some time ago, but I have not received no outcome." . The service had received 19 complaints within the last 12 months. The regional manager told us they reviewed all complaints to ensure action had taken place before they were closed.

The provider told us prior to people moving into the service, the local authority carried out an assessment of people's care needs. These assessments were used as part of care planning, which the provider confirmed involved the person receiving the care as well as their family or other representatives. However as mentioned previously people were not able recall if they had been involved in the planning of their care. The provider told us care plans were reviewed annually or as people's needs changed. Some people confirmed this and told us they had been involved in this process. For example one person told us they were involved in the review of their care and their family member was invited to attend which was important to them. Another person told us how their care plan was updated if there was a change they said, "If anything changes it's put in my care plan."

People who used the service were able to decide how to spend their day. The communal areas at the service were accessible to people and included a shop, restaurant and hairdressers. We saw people spent time in the communal areas; received visitors and also accessed the wider community.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection visit, we had received concerns regarding the lack management support available at Comfort Call Sunnyfield. At this inspection visit we received further concerns about the management arrangements at the service. Some care workers did not feel confident with speaking with us; they told us they were worried about possible repercussions from the provider. Care workers told us a manager was needed at the service with strong leadership skills, maintaining professional boundaries and taking appropriate action when required. For example to address staff absenteeism.

People were not clear regarding who the manager was for Comfort Call Sunnyfield. There was a housing manager on site, which caused confusion regarding which manager was responsible for which aspect of the facility. People raised concerns how the service had been managed. People told us the current manager was nice and had genuine interest in their well-being. However comments from relatives included "I would not recommend Comfort Call Sunnyfield, as there is no consistency and we are not told what's happening. The management of the service is not stable." People and relatives told us they did not feel confident if they raised concerns with the provider, the issues would be dealt with.

Care workers expressed frustration with the lack of continuity in management and leadership. One care worker said, "The management cover has been horrendous, you don't get told about the changes in management. The communication is not good." Another member of care staff told us, "I don't think the change in managers has been great. We don't get told what's happening each time the procedures change." Another member of staff stated, "We need management to listen and to be receptive to what we say."

The majority of the care workers we spoke with felt they were not supported by management effectively. One care worker said, "We don't feel supported, there have been no proper management arrangements to support us." Another care worker stated, "We have not always been able to get hold of management when we have needed support and advice." Another care worker said, "There is no consistency, we get told different things. The management and leadership at the service was not effective to ensure staff were supported and managed at all times and clear about their lines of accountability.

We received information from the Local Authority contracts monitoring team during 2016 that suggested issues raised with the provider were not fully addressed and that they had meetings with the provider to discuss contractual issues. They were also concerned about the lack of consistency in the management of the service. The current registered manager at the service had been off work since November 2015. The provider put into place interim management arrangements, to provide day to day management support to staff. During this period the covering manager stepped down from the position, which resulted in a registered manager within the same provider group providing management cover for part of the week. After a period of time this management cover stopped.

We discussed the concerns around the management of the service with the regional manager, such as care workers feeling that they were not being supported. They told us a new manager had been appointed into this position recently and they would be submitting an application to register with us. The regional

manager told us the new manager would be supported by the regional manager until they settled into the role and were familiar with the responsibilities of the role. In addition to this support a registered manager from another service from within the same provider group would also be supporting the new manager. The provider had recognised the new manager did not have previous management experience and told us they would ensure relevant training opportunities and support was available to support and develop them in their role.

There was an out of hours on-call system which care staff confirmed and people using the service confirmed. However, the on-call system in place for supporting care staff was not effective. For example we were told during the weekend in an event of an emergency, there was no management cover. Care staff told us when they had contacted the management at the weekend they have not always had a response until the Monday, which has meant they have had to deal with situations as they arose.

The provider did not have effective quality monitoring measures in place to drive improvement. People we spoke with did not recall being asked to give feedback on the service they received. One person said, "I've never filled in a questionnaire while I have been getting my care." Other people felt it would be a good idea to provide feedback on the service they received. We were told satisfaction surveys were sent out annually by the head office, who collated information and produced a report on the feedback and if required an action plan for the service. This information was not found at the inspection visit. We asked the management who was providing support at the service, to send us the results of recent satisfaction surveys. However, we did not receive this information. The provider could not demonstrate people's views were being used in the development of the service.

Accidents and incidents were logged by care staff through completion of incident form and submitted to managers. This information was collated by the manager who updated the electronic monitoring system, which produced quarterly reports. We looked at the report for June to August 2016, which showed no accidents or incidents were recorded for the quarter. However, records showed that staff had reported and recorded a significant number in the incident file which we discussed with the regional manager. Following the inspection visit we received information from the provider with an analysis of incidents and accidents during this period. However there was no information on the lessons learnt or actions taken to address any shortfalls identified. Therefore systems in learning from incidents to ensure that improvements to the quality and safety of the service provided were not effective.

The provider did not have a system to assess the number of staff that were required, to meet the needs of people. Therefore the provider could not ensure there were sufficient numbers of staff deployed to meet people's needs and preferences.

We found care plans and risk assessments had not always been updated to reflect people's current needs. For instance, one person had been assessed as 'mobilising with a trolley'. We observed the person walking around the communal areas using a walking stick. Another person was described as having skin damage. However the body map in the person's care plan had not been completed and there was no further information on the location of the skin damage or the level of damage. The care plan recorded and care worker confirmed that the person was receiving support from the district nurse who dressed the area. There was no guidance as to how care workers could support the person to reduce the risk of further skin damage. Care records did not always contain current and accurate information on people's needs. The lack of maintaining accurate care records placed people at risk of inappropriate or unsafe care because their well-being could not be monitored effectively.

Before the inspection visit, we asked the provider to complete 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. However this had not been returned to us. We spoke with the regional manager who confirmed that the PIR had not been received. The regional manager confirmed they would be looking at their systems to ensure correspondence received in the manager's absence was accessible by the provider.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of quality monitoring an internal audit was carried out during June 2016, which came out as high risk. As part of the audit, a sample of care records and staff files were audited, as well as service management, security, safety and feedback from four people using the service. Out of the four people who provided feedback, one person was not satisfied with the overall service. The audit identified areas for improvement. These included gaps on three people's medication records were identified and a risk assessment for a person was not fully completed. An improvement plan was in place, addressing the issues identified.

The provider knew and understood the requirements for notifying us of all incidents of concern as required within the law.

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 People's care was not person centred and was not reflective of their personal preferences. People's involvement in their assessment and planning of their care was limited and was not reflected in people's care plans. Regulation 9 (1) (3) (a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have effective processes to ensure safe management of medicines. People were not always protected against the risks associated with poor medicines management. Regulation 12(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care being provided and restricted the development of the service. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations.

Regulation17(1)(2)(a)(b)(c)(e)