Comfort Call Limited

Comfort Call - Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 was an announced inspection carried out on the 17 May 2016. At the last comprehensive inspection in October 2015 we rated the service as requires improvement. At that inspection we found two breaches of regulation; people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines and there were not always effective systems in place to manage, monitor and improve the quality of the service provided.

After the inspection in October 2015, the provider wrote to us to say what they would do to meet the regulations in relation to each breach. They told us they would complete all actions by the end of January 2016. At this inspection, in May 2016, we found that the provider had not completed their plan of action and legal requirements were still not met. We also found additional breaches.

Comfort Call-Leeds is a domiciliary care agency which provides personal care to people living in their own homes in the Leeds and Kirklees area. At the time of the inspection there was a registered manager in post. 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 and associated Regulations about how the service is run.

Medicines were not managed consistently and safely. Safe medicine administration practices were not followed so people were not protected against the risks of unsafe management of medicines. Although staff had received training in managing medicines, this had not given staff the required competency to manage medicines safely. People had not always received their medicines as prescribed, resulting in potential harm.

The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not always implemented and the provider's quality monitoring systems had failed to identify significant concerns.

People did not always receive their care and support as planned as staff had missed some people's calls and did not always spend the agreed time on the calls; cutting them short if they did not have enough time to get from one call to the next. Where people had regular care staff they spoke highly of them. However, people told us they did not have consistent staff at weekends and this meant they had calls from staff they were not familiar with and who did not know their needs.

There were not always effective systems in place to respond appropriately to complaints and comments made by people who used the service or people acting on their behalf. People who used the service were not confident that their comments and complaints were always listened to and dealt with effectively.

Staff training records showed staff had completed a range of training; however full records of induction training were not available to show this had been completed thoroughly. Staff knew what to do to make

sure people were safeguarded from abuse and any risks were managed to ensure people's safety.

Staff were able to demonstrate the different ways in which they helped to protect people's privacy and dignity and could describe the individual needs of people who used the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this 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?

Inadequate

The service was not safe.

People's medicines were not managed safely.

People did not receive their care and support as planned as staff were not always effectively deployed to provide the care people needed.

People were safeguarded from abuse. Safeguarding incidents were reported to the relevant agencies. Recruitment practices were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training records showed staff had completed a range of training; however full records of induction training were not available.

Staff said they received good support overall but commented that on call and office support was not always available when needed.

The service provided support with people's meals and healthcare when required.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with gave mixed views about the service but said staff were kind and caring, treated them with dignity and respected their choices.

Staff we spoke with knew the people they were supporting well and were confident people received good care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were not always effective systems in place to respond appropriately to complaints and comments made by people who used the service or people acting on their behalf.

People's needs were assessed before they began to use the service and person centred care plans were developed from this information. However some people who used the service said unfamiliar staff were not always aware of their needs.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

People were not protected from unsafe care as the systems in place to monitor the quality of the care people received were not effective.

People who used the service were not consistently asked to comment on the quality of care and support through surveys or effective day to day contact.

Comfort Call - Leeds

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 17 May 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 at the location. The inspection team consisted of one adult social care inspector, a pharmacist inspector, a specialist advisor in governance 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.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications. Before the inspection providers are sometimes asked 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. We did not ask the service to provide us with a PIR prior to this inspection. We contacted the local authority and Healthwatch. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of our inspection there were 90 people receiving personal care from Comfort Call- Leeds. We visited five people who used the service to look at their medication and associated documentation. We spoke by telephone with eight people who used the service, four relatives and five staff. We also spoke with the registered manager, regional manager and a care co-ordinator. We visited the office of the service and spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at five people's care records and six people's medication records.

Inadequate

Is the service safe?

Our findings

At the previous inspection in October 2015 we found the provider did not have systems for the proper and safe management of medicines. At this inspection we found similar concerns. We found concerns about safe handling of medicines for all the people whose records we looked at.

We found some improvements in the standard of record keeping had been made since our last inspection. However we found the records were still not always fully completed which meant it was not always clear which medicines had been given or taken. We saw there was good information recorded to guide staff as to when and where to apply prescribed creams and the records about the application of creams showed they were being applied properly. We spoke to care workers who applied creams and they had a good knowledge of the creams they were applying and why they were needed.

A medicines risk assessment was made for each person that explained the support they needed with their medication. We found the assessments were not always completed properly. One person was assessed needing, 'level 1' assistance, which meant they had been assessed as safe to look after their own medicines with only occasional prompting. The company policy explained that occasional prompting meant that they did not need to be prompted more than two or three times a week. If the prompt was more frequent, the person should be reassessed as they may need more support. We saw that this person needed full support with their medicines. When we visited this person in their home they told us they had "no idea" where their medicines were kept because they were "hidden" from them for safety. This meant that the person was not able to look after their medication at all because it was unsafe for them to do so. The care workers notes sometimes recorded they had 'prompted' medicines or 'given' medicines and on other occasions they recorded 'left meds on the table' for the person to take later on. This person had short term memory loss so this was not a safe way to administer their medication. The risk assessment and the records did not show how they were safely supporting this person with their medicines.

We discussed the failure to follow policy with regard to prompting and administering medicines with the registered manager and regional manager, who told us they had not understood the difference in the terminology, used and had not been aware the policy was not being followed. The registered manager also told us that the levels of support people needed had not been reviewed as people's needs changed.

We found that the provider failed to keep sufficient information about how individual people were supported with their medication. There was no information recorded as to exactly what medicines each person was prescribed so it was not possible to tell if people were being given all their prescribed medicines. There was no information as to whose responsibility it was to order medicines and we saw that two people had run out of one of more of their medicines. Which placed their health at risk of harm.

We saw that some people had been assessed as having 'time critical' medication but there was no information as to which medicines these were and at what times they should be given. We saw people were prescribed medicines which should be given 30 minutes before food. We found that no arrangements had been made to accommodate this. The registered manager confirmed that it was possible to give these

medicines before food because most people had long enough calls to enable medicines to be given in a timely manner. We saw that one person was prescribed medication for diabetes which must be given with breakfast each day. However we saw that on a number of occasions the breakfast call was very late and the person's care workers recorded that on their arrival the person had had their breakfast. On other occasions the person had refused food after they had taken their medication which placed them at risk. There was no information recorded in the care plan to guide staff about how to identify the signs of them becoming unwell due to high or low blood sugar levels or what action needed to be taken.

We saw some people were prescribed medicines to be 'given when required'. However there were no care plans in place to guide staff as how to give this type of medication safely and consistently. We saw one person was prescribed a paracetamol containing analgesic. Paracetamol must be given with at least a four hour time interval between doses. The planned call times were less than four hours apart which meant this medication could not be given safely. We examined the MAR records for seven randomly picked days and saw that on all seven days they were given the tablets four times a day and only on two occasions was the time interval over four hours. This person's health was placed risk of harm. A staff member we spoke with said they thought paracetamol could be given three and a half hours apart which is against the manufacturer's instructions and could place people at risk of harm. All other staff spoken with were aware of the need to ensure an interval of at least four hours.

We saw two people were prescribed a thickener to make sure they did not choke when drinking liquids. For one person, there was no information available, in their home, to show how thick to make their drinks. The staff member told us that they used one scoop but they were unaware of how much liquid the cup held; the volume determines the numbers of scoops needed. We saw that the person had two drinks beside them and neither was thickened to the minimum level of thickness. We also saw in the care notes, it had previously been recorded that the person had been choking while drinking and at another time was very chesty. We also saw that their thickener ran out and this placed their health at significant risk of harm. Three staff currently or had previously supported people with thickening powder for their drinks. They described safe practice and the importance of following the care plan instructions regarding consistency of drinks. They confirmed this had been or was available to them. They spoke of the instructions being specific to the size of the cup.

We saw that there was no method of checking if people had been given the correct medicines on the correct days because no records were made as to when the blister packs were started or for medicines not in blister packs, how much medication was in their home each month. We saw that two people had their medicines stored in a special safe. However we found one safe was very wet and the medicines had been placed on top of a very wet tea towel and another person's medicines were not all kept in the safe and several bottles of medication had been left on top of the safe. This placed the person's health at risk of harm.

Although senior staff had audited the medicines administration records (MAR), the audits had not always identified the concerns we found at this inspection. For example, audits had not identified where records showed medication may not have been given or where medicines had been administered too frequently.

We therefore concluded there was an on-going breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service said they had a small number of regular care workers who they saw Monday to Friday. They all said they valued the fact that they have been able to get to know the care workers. However, all those spoken with described the fact that they would invariably see a staff member at the weekend that they had not seen before and it would be a considerable amount of time before they would then see them

again. People said they disliked the fact that on Saturday and Sundays they would have to describe in detail exactly what it was they needed doing for them. One person said, "They need to have more staff so that it isn't always somebody different every weekend that I've never met before. It they did that, it would mean that I would have the same quality of care at the weekend as I do in the week and I wouldn't worry so much then." Another person said, "I really do get fed up with having to explain over and over again every Saturday and Sunday to somebody new, what it is I need help with. I dread the weekend coming and then can't wait for Monday to come along when my regular carer will be back again."

All staff said they worked in small teams to ensure people got the same staff for their calls; they said this now included weekends. However, staff said there was not always opportunity to be introduced to people before they provided the care as they had to cover emergencies and some people's service began without much notice such as when they came out of hospital.

The registered manager told us staffing levels were determined by the number of people who used the service and their needs. They said the provider was always trying to recruit staff to ensure they had enough staff to meet the needs of the people who used the service and provide consistent staff support for people. However, records we looked at showed people did not always receive support as planned. We looked at the log books completed by staff and these showed staff did not always stay the agreed allocated time. We looked at three random records; checked 13 dates where people had four daily visits and saw there were shortfalls each day ranging from 15-66 minutes across the day. This meant there was a risk people did not receive the care they needed. One person told us they had had three calls missed in the last few months. They said they had reported this and nothing as yet had been done about it.

All staff we spoke with said they stayed the required amount of time unless people or their families told them to leave if finished; they said they would document this if that was the case. We did not see this documented in the records we looked at. One staff member said there used to be a problem with calls overlapping which meant they had to catch up, rush things and do shorter calls. They said this was much improved in the last couple of months as the geographical runs were much better organised and they had time to get to visits in a timely way. One staff member said they sometimes felt rushed as people needed more time. They said they reported this but nothing had been done about it.

We concluded there was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive their care and support as planned as staff were not always effectively deployed to provide the care.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. All the staff we spoke with said they would report any concerns to the registered manager. Staff said they were confident the registered manager would respond appropriately. Staff told us they had received training in safeguarding vulnerable adults. Records we looked at confirmed most staff were up to date with this. The provider had safeguarding procedures and information about the local safeguarding authority. The management team understood how to report any safeguarding concerns.

We reviewed risk assessments for five people who used the service. There were systems in place to keep

people safe through risk assessment and management. We saw individual risk assessments were completed and included falls, mobilising, skin integrity and the environment.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received good training and were kept up to date. One staff member said they thought the training could be better. They said they felt it should go in to more detail and depth. All staff we spoke with said they received a good induction which had prepared them well for their role. Staff told us they had 'shadowed' experienced staff or a care coordinator as part of their induction training to ensure their practice was of the standard required. One staff member said, "I felt confident after doing that (shadowing)."

The registered manager told us there was a written record and assessment completed during shadowing which was carried out by mentors who were either senior staff such as care co-ordinators or experienced staff with an exemplary record. However, we looked at the records of six new staff and saw there were no shadowing records completed for five of them. The registered manager could not explain this but assured us the shadow shifts had been completed to make sure staff were competent.
There was a rolling programme of training available which included moving and handling, safeguarding, first aid, prevention of infection, food hygiene and dementia care. The registered manager told us that all new starters now completed the 'Care Certificate'. The 'Care Certificate' is an identified set of standards that health and social care workers adhere to in their daily working life. The training record showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date.

Although training had been provided in managing medicines our findings showed this had not provided staff with the competency to manage medicines safely. Some staff had received additional support and supervision sessions to improve their competency. However, we did not find any evidence that this was then monitored closely to ensure staff's on-going competency.

Most people we spoke with told us they thought the staff were competent to carry out the care tasks that they, or their family members, needed. One person said, "My husband has two carers each time because he needs hoisting and I must admit his regular carers make him feel very safe and they're always there to explain to him what is happening. They seem to be adequately trained in using the hoist and if he is happy, then I am happy." Another person said, "My regular carers know exactly what it is they are doing and I think that their training is excellent."

People were not as complimentary about the competence of staff who cared for them at weekends when it was reported that staff who came to them were not always regulars. One person said, "I appreciate it is difficult when, at the weekend they're only going to see me once in a blue moon, I can't expect them to remember what I need." Another person told us, "It's just those that come at the weekend when it can be more difficult and they rely on me to tell them what I need doing."

Staff we spoke with told us they were well supported by the management team. Staff said they received regular one to one supervision and 'spot checks' to assess their performance and competence. Records we looked at showed this to be the case. Staff said they found this support useful and a good opportunity to discuss their job role, receive any feedback and review training needs. However, two staff members said they

could not always get support from ringing the office or the on-call system if they had a problem as the office or on-call staff could also be out providing care. They said this could create anxiety for both staff and people who used the service.

The Mental Capacity Act (2005) provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make specific decisions for themselves. We asked staff about the Mental Capacity Act 2005 (MCA). They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions. Staff we spoke with confirmed they had received training on the MCA. Training records showed a number of staff still required this training. The registered manager and regional manager said there was a plan in place to ensure all staff completed this training.

Our review of records showed people who used the service were asked to consent to their care, access to their home and mail. There was information available to show how people indicated their consent and whether this was verbally or non-verbally. One person who used the service said, "I definitely make my own decisions and if I don't feel quite like starting with my shower as soon as my carer comes in, I will ask her to go and do some of the other jobs first and then will shower me when I am ready." Another person said, "I definitely like a certain way for doing things and my regular carers are lovely and will always make sure that they do things in the way I like them to be done particularly when they are getting me dressed after I've had my wash. I certainly would never find a problem with telling the carers that I like things to be done in a certain way."

People we spoke with who had meals prepared by care workers told us they were satisfied with how this was done. Comments included; "My carer will put everything on the tray for me and bring it through to the lounge where I sit with it on my lap. Whilst I am eating she will make me up a flask of tea for the afternoon and put me some fruit out for my dessert" and "My carer will always ask what I would like in my sandwich and again when she does my hot meal she will tell me what choices I have in the fridge and then let me decide what I'd like." Another person said, "My carer always makes me up a flask of hot tea for the afternoon and I find that really helpful because I hate having to go all afternoon without having something warm to drink."

We found people who used the service or their relatives dealt with people's healthcare appointments. However, one relative told us, "My mother wasn't feeling very well a couple of months ago when her carer got to her, so she rang me straight away and I went round to see what was wrong and to sort mum out. I'm always grateful when the carers contact me because I'd rather know sooner than later in case things escalate and she ends up being taken to the hospital." Staff said they were trained to respond to people's ill health and would report any concerns or have no hesitation in calling the emergency services if needed.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the caring attitude of the care workers. One person said, "I like the fact that I have two lovely regular carers who I see most of the time. I know it sounds selfish, but I wish they didn't have any time off because it's not the same when they are not here. The best thing is how supportive my carers are and how well they look after me, they are really like good friends or family members." Another person said, "The carers are all lovely, I cannot fault them and they couldn't be more polite. I have no issues with the carers whatsoever." A third person told us, "My regular carers who come, couldn't be any kinder. They never mind doing extra jobs for me. They always make sure we have a chat while they are looking after me."

People told us their, or their family member's, privacy and dignity were respected. One person said "My carer always make's sure that the curtains are shut in the evening before we start undressing me and getting me ready for bed." People said staff encouraged and supported them to maintain their independence. One person commented; "I struggle these days and have to walk with my Zimmer frame because I'm very worried that I might fall over. My carer is very good and will walk behind me and encourage me to get about as much as I can when she is here with me in order that I can still do some walking on my own."

Staff we spoke with showed they had an understanding of people's likes, dislikes and care preferences. They spoke warmly about the people they supported. They said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. They spoke of the importance of helping people to maintain their independence. One staff member said, "That's what it is all about; keeping people going and helping them when needed."

We looked at the care records of people who used the service and saw there was evidence that people or their family members were involved in planning the care or support they or their family needed. One person told us, "When I had the initial meeting with the agency my husband came along with me so that we could both talk about what help I needed."

We also saw that people who used the service had a 'My Life Story' section in the care records. This contained person centred information about people and demonstrated some time had been spent talking to them and getting to know them. Staff spoke about the importance of respecting people's history and past and making sure they knew the importance of it. This showed they valued people as individuals.

Requires Improvement

Is the service responsive?

Our findings

We found evidence of a complaint that had been made by a relative regarding a query over a timing of a call and the support provided. The relative was disputing the timing of the call and care and suggesting the record had been falsified. This had not been reported to the registered manager by the staff member or the care co-ordinator. The complaints procedure had not been followed. A co-ordinator had taken a statement from the care worker who gave a conflicting account in response to the concerns raised. No further action had been taken.

The registered manager was not aware of the concerns that had been raised. We brought this complaint to the registered and regional manager's attention and they said an investigation would commence immediately. The registered manager contacted the relative on the day of our visit to apologise and inform them they were looking in to their concerns and would keep them informed of the outcome of their investigations.

We also saw a relative had raised concerns during a telephone quality assurance call carried out in December 2015 and there were no records of any response to these. People who used the service were aware of the complaints procedures and knew who to speak to if they needed to raise concerns. However, one person told us, "If I see [Name of registered manager], I will talk about the difficulties with the carers at weekends and also the problems with the office staff. Unfortunately, whilst he will listen to me he hasn't really been able to do anything about any of my concerns." Another person also said, "I honestly can't say anything has really changed at all, as a result of my conversation with [Name of registered manager]. Perhaps if I made it into a formal complaint, it may be treated differently, but I very much doubt it."

We concluded there were not always effective systems in place to respond appropriately to complaints and comments made by people who used the service or people acting on their behalf. This was a breach of Regulation 16, Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that any learning from complaints or concerns received was communicated to staff. They said they did this through direct contact with staff or by sending memos out. We looked at a sample of correspondence with staff in the memo file. We saw in April 2016 staff had received memos about the importance of attendance at supervision, timesheets not being sent to the office on time and medication issues. In March 2016, memos included a fact sheet on record keeping. This was in response to some negative feedback received from the local authority. In October 2015 staff received a memo reminding them to stay the allocated call times as per their rota. This method of communication with staff was not effective to ensure learning from concerns or issues raised as our findings showed there were still concerns with medication and call times.

Records showed that people had their needs assessed before they began to use the service. This ensured the service was able to meet the needs of people they were planning to provide a service to. The information was then used to complete a more detailed care and support plan which provided staff with the information

to deliver appropriate care.

Care and support plans contained details of people's routines and information about people's health and support needs. Information was person centred and individualised. Examples we saw included; 'Turn the gas fire to low and close the curtains', 'At all times one carer is to tell me what is happening', 'Give me time to understand and to co-operate with you' and 'Switch the TV to channel 103'.

People who used the service told us in the main, they received their care preferences. One person said, "My carer knows I like warm towels ready when I get out of the shower and she always make's sure she puts them on to the heater before we start so that they are lovely and warm when we are finished." Another person said, "I'm very happy with the times I have. It means I can get up and go to bed at the times I like to and I know that with the key safe on the front door, the carers can let themselves in and out and I am still secure here in my home." However a person also told us, "My regular carers know me really well, unfortunately, the carers at the weekend, I may only ever see once, so they don't get the opportunity to get to know me at all."

Staff told us care plans contained all the information they needed to provide the right care and support for people. They said they had chance to read them and were kept informed of any changes in people's needs. One staff member reported a recent difficulty where they had not been able to locate a person's medication as the storage place had changed. They said they had not been able to easily identify where the updated information was in the care plan.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. They were registered as a 'registered manager' by the Care Quality Commission in February 2016 so were not in post at the inspection in October 2015.

At our previous inspection in October 2015 we found the provider did not have effective systems in place to manage, monitor and improve the quality of the service provided. We found similar concerns at this inspection. Although some systems to monitor the quality of the service had improved; they had failed to identify the issues we found. Where audits had been carried out and actions identified, they were not supported by clear, evaluated action plans to ensure safety and service improvement.
At this inspection we identified that medicines were not managed safely. Audits on medication consisted of a monthly check on report books. The sample we looked at did not show clearly how an overview of medication was gained; there was no analysis of the information collected to show where quality and safety were being compromised. Any actions identified such as 'finished medications not documented correctly' and 'Gaps in MAR chart' were not supported by action plans to show how issues had been addressed to prevent re-occurrence and ensure improvements.

We also saw the reports books were checked each month for the entries made by staff at their visits to people. The checks showed concerns on call times were identified which included; 'Entries not concise and factual', 'Lots of gaps in times' and 'call times significantly shorter than allocated times and missing signatures.' Again we found this information showed no evidence that any action was taken to ensure improvement.

These audits did not generate any action plans to show how the service had responded to findings and created improvements in the service. They were still not robust enough and did not show how patterns or trends were identified.

The care provider sent out annual questionnaires for people who used the service and their relatives to enable them to comment on the service. We were told the last survey undertaken was in May 2015 and questionnaires for May 2016 had just been distributed. The registered manager confirmed no action plan had been developed from the 2015 survey and did not know if any issues raised by people had been addressed. This meant they had not used this information to make improvements in the service. A person who used the service said, "They may have asked me to fill in some sort of survey but it would've been a good long while ago and I certainly don't remember ever hearing anything about what happened to it or whether anything was going to change as a result of it."

The registered manager told us that people who used the service or their relatives were contacted every three months for a quality audit via the telephone (Telephone Service Quality Check) and that they aimed to visit people once a year. We looked at the records for four people and found two of the four people had not received a quality check in the last seven months to enable them to give their views on the service. People also told us they were not asked for their views about the care and support the service offered. People's comments included; "I don't remember ever being asked my opinion about the service and I've been with

them for the three years they've been in business. I think you're the first person to ask me how I feel they could improve", "I wouldn't know how to begin to influence any change in the quality of the service. No one has ever asked me my opinion and when I do phone the office to talk to them, I really don't feel that I'm valued by them at all" and "You can't really help improve things if nobody asks you what your opinion is.".

We also found a quality assurance call carried out in December 2015 showed a relative raised concerns that staff did not stay the full time required and there was a variation of call times. Records showed no action had been taken in response to this.

People who used the service and their relatives were critical about the attitude and organisation of the office staff. They said communication was poor and they felt they had to "chase" information and the office staff were not good at returning calls. Comments we received included; "The office side of things and the communication is quite frankly very poor. It's always me that ends up chasing the office to find out why carers are running late or why they haven't come at all. They always promise to phone back and never do and it just doesn't instil any confidence in you that they know what they are doing" and "I do sometimes feel like I am talking to a blank wall when I call the office because I never ever get anything from them the first time I call and I constantly end up chasing them rather than me picking up the phone to hear them telling me what the answer is" .

Other comments we received on the management of the service included; "I don't think the managers are very visible at all. I couldn't even tell you who the managers were and I certainly haven't seen anyone come to visit me calling themselves a manager in the 18 months I've been with them", "I honestly couldn't really tell you who the manager was, let alone whether they have visited me or not" and "[Name of registered manager] is a lovely man to talk to and he is very caring when he is covering some of the carers work, but I don't really think he has any answers to the problems of shortages of carers or even trying to get the office staff to call back when they say they will."

Staff spoke positively about the new manager; said they were organised and hardworking and would help with covering calls if they needed to. They said they felt the agency was "back on track" with call times, all much better organised more recently. Two staff members said there were sometimes difficulties in getting hold of someone at the office or the on- call if they were covering calls. Others said there was always someone available to help at any time of day, evening, weekends. One staff member said there were some care workers they didn't feel were as committed as others and "let the side down". They thought the agency was addressing this through performance management.

The registered manager and regional manager told us they had a monthly meeting and a report was completed called the 'Monthly Branch Return'. We looked at two recent reports which showed a number of areas had been discussed. These included progress on medication issues, call times and missed calls. Internal audit scores were given but there was no indication of how this was generated. There was no evidence to show how this review of service had ensured on-going improvement.

At this inspection we identified there was a lack of recording and evaluating information about the quality and safety of the service and concluded the provider's systems and processes were not effective. This was a continued breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There were not always effective systems in place to respond appropriately to complaints and comments made by people who used the service or people acting on their behalf.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive their care and support as planned as staff were not always effectively deployed to provide the care.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to manage, monitor and improve the quality of the service provided were not effective.

The enforcement action we took:

Warning notice