Westminster Homecare Limited

Westminster Homecare - Sheffield

Inspection report

Redlands Business Centre
3-5 Tapton House Road, Broomhill
Sheffield
South Yorkshire
S10 5BY

Tel: 01142669996

Date of inspection visit:
10 August 2016
11 August 2016
17 August 2016

Date of publication:
29 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

There was a manager at the service who was registered with CQC. 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.

This was first time this service has been inspected by the Care Quality Commission. The service was registered with the Care Quality Commission on the 19 October 2014.

Most of the people we spoke with felt "safe" and this feedback was reflected in the questionnaires we received. A few people told us they did not feel "as safe" when they were being supported by staff they had never met before.

We found the systems in place to manage and support people with their monies were not robust and did not safeguard people from financial abuse.

Most people who received support from regular workers for all or most of their care package were satisfied with the quality of care they had received. However, some people did express concerns about late calls being delivered.

People who did not have regular care workers told us they wanted to be supported by regular care workers and not to experience late calls.

We received mixed views from relatives regarding the quality of care their family member had received. Some made positive comments about the care their family member had received whilst others made negative comments.

Individual risk assessments were completed for people so that identifiable risks were managed but these were not being regularly reviewed to ensure they reflected people's changing needs.

We found the provider had not ensured there were appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

There were robust recruitment processes in place. This told us people were cared for by staff who had been assessed as suitable to work at the service.

Staff received training and ongoing support to enable them to support people appropriately.

The feedback we received from people, relatives and the review of people's records told us the scheduling and delivery of care calls required improvement to enable all the people using the service to experience

continuity of care.

We received mixed views from people regarding the staff. For example, some people made very positive comments about the staff in particular their regular workers and said they were caring. Some people told us that some staff did not communicate well and did not speak whilst delivering calls.

We found people's care plans had not been reviewed regularly. We found the provider had not ensured that people using the service received person centre care that was appropriate, met their needs and reflected their personal preferences, whatever they might be.

We found the service had a robust process in place to enable them to respond to people and/or their representative's concerns, investigate them and had taken action to address their concerns.

Accidents and untoward occurrences were monitored by the registered manager and operations manager to ensure any trends were identified.

We found the provider's systems and processes to assess and monitor the service had been ineffective in practice.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were a breach of Regulation 9, Regulation 12, Regulation 13 and Regulation 17.

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?

Inadequate

The service was not safe.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

The provider had not ensured that risk assessments relating to the health, safety and welfare of people using the service were reviewed regularly.

We found the systems in place to manage and support people with their monies were not robust and did not safeguard people from financial abuse.

Is the service effective?

Requires Improvement

The service was not effective in some areas.

The scheduling and delivery of care calls required improvement to enable all people using the service to experience continuity of care.

Staff received training to maintain and update their skills. Staff were supported to deliver care and treatment safely and to an appropriate standard

Is the service caring?

Requires Improvement

The service was not always caring.

Some people and their relatives made positive comments about the staff and told us they were treated with dignity and respect. The staff were described as being kind, caring and approachable.

Some people made negative comments about some of the staff supporting them and told us they did not communicate well.

Is the service responsive?

Requires Improvement

The service was not responsive in some areas.

Care plans were not reviewed regularly and in response to a change in people's needs.

The service had a robust process in place to enable them to respond to people and/or their representative's concerns, investigate them and had taken action to address their concerns.

Is the service well-led?

Requires Improvement

The service was not well led in some areas.

The registered manager was visible and actively managing the service and was able to describe the individual needs of people who used the service.

The provider completed regular checks at the service to assess and improve the quality of the service provided. However, we found the checks had been ineffective in practice.

Westminster Homecare - Sheffield

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 checked 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 the 10, 11 and 17 August 2016 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we wanted to ensure the registered manager was available.

The inspection team was made up of two adult social care inspectors and two experts 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. Their area of expertise was in supporting people to use domiciliary care agencies.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We sent out 100 questionnaires to people who use the service and 93 questionnaires to Westminster Homecare-Sheffield staff before we inspected the service. Twenty nine people and four relatives on behalf of their family member returned questionnaires to us. Twenty two staff returned questionnaires to us. We contacted 25 people by telephone and spoke with 17 people and two relatives. We visited six people who were using the service. We also spoke with seven staff by telephone.

We visited the service's offices on 10, 11 and 17 August 2016 and spoke with the registered manager, operations manager, branch trainer, two care co-ordinators, a field supervisor, a quality officer, a senior care worker and two care workers. During the inspection we spent time looking at written records, which included seven people's care records, eight staff records, a sample of peoples rotas and medication

administration records and other records relating to the management of the service such as training records and quality assurance audits and reports.

Inadequate

Is the service safe?

Our findings

Most of the people we spoke with felt "safe" and this feedback was reflected in the questionnaires we received. A few people told us they did not feel "as safe" when they were being supported by staff they had never met before. Peoples comments included: "I do feel safe with them but my missus has short term memory and it's better if we have regular people coming round so she can recognise them, I've asked but they [office staff] said they were understaffed", "don't ring if we are getting someone different, we get strangers [care workers]" and "I feel safe, but some of them [care workers] are straight out of school and I have to tell them what to do". Most people told us staff wore their ID badge and uniform. A few people told us there were occasions when staff didn't. One person commented: "they do wear a uniform and a badge mostly but some don't and we don't know who they are when they come to the house".

We received mixed views regarding the staffing levels at the service. Most people who received support from regular workers were satisfied with the quality of care they had received. However, some people did express concerns about late calls being delivered. People who did not have regular care workers told us they wanted to be supported by regular care workers and not to experience late calls. Peoples comments included: "I would just like regular carers so they know what time to come; there is too many new faces as they do not keep to the rota I have asked for", "the service is irregular at times. I never can be sure who will turn up sometimes", "times of attendance varies depending on each different carer" and "poor timekeeping, regular changes in care workers and poor conditions for care workers are the main problem". People told us some staff explained the lateness of calls was due to them having to walk between calls. The operations manager confirmed that 75 percent of the care staff did not drive so they needed additional travelling time and some areas of Sheffield were physically challenging because of the hills. The operations manager told us they were reviewing the rotas geographically with the registered manager with the view of reducing travelling time and reducing the risk of late calls.

At the time of the inspection the service was using agency staff to ensure people received their care calls and there was rolling programme in place to actively recruit new care staff. The registered manager told us that if a person required support from two care workers, an agency staff member would work alongside a member of staff employed by Westminster Homecare.

Individual risk assessments were completed for people so that identifiable risks were managed but these were not being regularly reviewed to ensure they reflected people's changing needs. The purpose of a risk assessment is to put measures in place to reduce the risks to the person so it is important these are completed regularly so they balance the needs and safety of people using the service with their rights and preferences.

We found the systems in place did not ensure medicines were administered accurately, in accordance with any prescriber instructions and at suitable times to make sure people were not placed at risk. During the inspection we were given a list of 12 people who required time critical calls. We found some people's time critical calls had not been scheduled on their rota as being time critical; this included people who were prescribed medicines that needed to be administered at the same time each day. For example, one person

needed to take their medicine at tea time each day. We reviewed the person's care rota for the last two weeks in July 2016 and saw the planned time for the delivery of their tea call varied and had not been scheduled as time critical. We also saw the actual time the call was delivered by care staff also varied. This showed some people were not being supported appropriately to manage their medicines. We spoke with the registered manager and operations manager, who took immediate action to ensure these people received their medicines consistently and in accordance with the prescriber instructions. The operations manager informed us that a full audit would be completed to ensure people's time critical calls were scheduled on their care rota.

We visited six people at their homes. We noted that five people were prescribed a medicine that should be taken a minimum of 30 minutes prior to eating for best effect. We found there were no arrangements in place to ensure the person took their medicine prior to eating. In addition one person had been prescribed a medicine that should be taken with food for best effect. We found there were no arrangements in place to ensure the person took their medicine with food. Four people we visited were prescribed external preparations, like creams and ointments. We found that none of the people had written guidance in place to explain to staff where to apply creams or how much to apply. One person we visited was prescribed a pain medication that should be administered no less than four hours apart. We found examples where the person's calls were being delivered too close together so the person was not being supported to take their medicine safely. We shared this information with the registered manager and the operations manager, who assured us that action would be taken to address each concern raised.

During the inspection we found examples where staff had failed to sign confirmation they had administered a medication. For example, in one person's care plan a Medication Administration Record (MAR) for Warfarin contained two gaps where staff had not signed; one gap in April 2016 and one gap in June 2016. We found no evidence that these omissions had been reported by care staff or they had been investigated. We reviewed a sample of the Medication Administration Records (MAR) the service had audited in July 2016. On one person's MAR chart we found staff had failed to sign to confirm they had administered a medicine the person received every seven days on two occasions in May 2016. These omissions had not been reported by staff or identified until the audit in July 2016. This showed the auditing of MAR charts required improvement. We spoke with the operations manager who informed us they would instruct staff to highlight the date on people's MAR chart for medicines that were not administered daily, so there was a visual reminder for staff to administer the person's medicine. The service would also be completing regular quality checks on MAR charts for all the people using the service. The service was currently reviewing a sample of 30 percent. Staff would also be reminded to report any omissions or concerns to the office promptly so they could be investigated and enable appropriate action to be taken.

We found the provider had not ensured that risk assessments relating to the health, safety and welfare of people using the service were reviewed regularly. We found the provider had not ensured there were appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. These findings evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the systems in place to manage and support people with their monies were not robust and did not safeguard people from financial abuse. The concerns we noted included the following: examples of staff not filling in the financial transactions records correctly or not recording transactions and people's financial transaction records not being audited regularly. The registered manager was in the process of auditing two people's joint financial transaction records and had seen that further improvements needed to be made. The operations manager told us the auditing of financial transactions records would be separated from the care plan audit and staff would receive further training. During the inspection the operations manager put

in place a bespoke financial transactions recording system for the two people who had a joint financial transaction record.

This showed the provider did not have appropriate arrangements in place to protect people from the risk of financial abuse. These findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the staff recruitment records for eight staff members. The records contained a range of information including the following: application, references including one from the applicant's most recent employer, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We noticed a gap in one person's employment history which had been noted by staff but not followed up. We spoke with the registered manager who assured us this would actioned. This told us people were cared for by staff who had been assessed as suitable to work at the service.

Most people and relatives spoken with did not raise any concerns about infection control and this was reflected in the information received from people who had completed a questionnaire. One person commented "quite good with hygiene; on one or two occasions not had gloves but usually have the equipment".

Requires Improvement

Is the service effective?

Our findings

We received mixed views from people about the quality of the care they received. Some people were fully, partially or not satisfied at all with the quality of the care they had received. People's positive and mixed comments included: "[care worker] is brilliant, no complaints at all", "I have two regulars who are brilliant they talk to me and get on with the jobs but as for the rest I don't know who is coming and some of the young ones don't know what they are doing I have to tell them", "we get a regular for a few days then it changes it depends on the rota in the office. We don't always know who is coming which we don't like but the girls who do come are generally good. It's the organisation of it that's bad but I must admit though, that some of them that do come can't understand English" and "get a good service, I'm satisfied with everything they [care workers} do".

People's negative comments included: "they [care workers] come when they come because they are always busy elsewhere and there is always an excuse of some kind but I think It's the office fault because they have no conception of distance and it is badly organised the girls are all over the place. If they are late they don't phone me I phone them but they always turn up eventually. There is no rota so I don't know who is turning up which I don't like", "new care workers arrive all the time who we have not met before. There is a not enough consistency of care", "I have an appointment at 10am. I rang and told them four or five times I've got an appointment. They [care workers] don't come till about 9:25am sometimes. I don't think it's on their computer, don't think they [office staff] take any notice", "I have had 40 different care workers (used the service for about a year)" and "being diabetic on insulin which I take myself. I often do my own breakfast when carers are late".

We received mixed views from relatives regarding the quality of care their family member had received. One relative commented: "I'm happy about the lads that come, he [family member] has got to know them and he is happy and confident when they come to the house. He has got to trust them. They treat him very well and we both like them because they are happy people and they seem very well trained in what they do. But we would like regular workers all the time". Another relative commented: "my main concern is that staff do not turn up at agreed times to provide medication, especially visits deemed to be 'time critical'. When confronted over this issue care workers tend to respond by indicating that they are working to the times given by their co-ordinator".

Some staff spoken with and the feedback received from questionnaires reflected their concerns about visiting different people every day and not getting to know people well. One staff member commented: "I don't feel that I have consistency in my work as I go to different service users each day which I feel does not give the service user continuity of care".

The feedback we received from people, relatives and the review of people's records told us the scheduling and delivery of care calls required improvement to enable people who use the service to experience continuity of care. For example, time critical calls needed to be inputted accurately in people's care rotas and delivered on time. Both care staff arriving on time if a person required support from two care workers. Care staff staying the allocated time so people did not experience short calls. Care staff reading the care

plan rather than asking for instructions from the person being supported. Care calls coordinated and delivered so people did not experience late calls or calls too close together or missed calls (which included late calls delivered out of the timeframe). Office staff always informing people if the care worker was going to be late in a timely manner.

We found the provider had not ensured that people who use the service received person centred care that was appropriate and met their needs. These findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the Mental Capacity Act 20015 (MCA). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. We saw staff received training in Mental Capacity Act 2005 and people told us staff sort consent prior to supporting them with their personal care. In people's records we saw examples where people had not signed their care plan to show they were actively involved in the assessment and had consented to their care plan. We shared this information with the registered manager.

Some people told us they were supported by staff who were well trained and did not have any concerns about their competency. Peoples comments included: "I do think they are trained I'm very satisfied I never think oh god I'm not safe, I'm very confident and comfortable in their presence" and "they [care workers] do all the proper things, the training seems thorough". However, some people expressed concerns about the training and competency of some staff who were not as experienced or new to working in care. One person commented: "the young ones could do with more training they ask me and I have to tell them what to do, they don't read the book [care plan]" and "got two that are very good, experienced and well trained, some [care workers] are just out of school, chaotic". These mixed views were also reflected in the feedback received via questionnaires and from people's relatives.

The branch trainer told us that new staff received a six day induction programme. They provided us with a copy of the programme they followed. We saw it reflected the fundamental Care Certificate Standards which is the new minimum standards that should be covered as part of induction training of new care workers. Staff spoken with confirmed they had completed induction training and shadowed staff prior to supporting people on their own. The branch trainer told us that agency staff also received a short induction to ensure they were following set standards. For example, the local authority medication procedures. We received positive feedback from staff who had attended induction training. One staff member commented: "the training I have received from the branch trainer has been very good and given me a clear understanding of my duties and responsibilities".

The service used a training software package to monitor the training completed by staff. Staff were assigned dates for when they needed to complete their training. The training provided covered a range of areas including the following: basic life support, people handling, health and safety, food hygiene, safeguarding, medication training, first aid, moving and handling, infection control, Equality Act 2010 and dementia. We saw there was a robust system in place to ensure staff received regular refresher training.

We saw examples where individual staff had received further training in areas when it had been identified they did not have an acceptable level of competency. For example, they required further training in the management of medicines.

We reviewed eight staff files. We also saw that care staff were spot checked to ensure they were competent to carry out their role. We found staff received regular supervision and an annual appraisal. Where there

was a gap in supervision an explanation could be provided by the registered manager. For example, the staff member had been on maternity leave. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months.

Staff spoken with confirmed they received regular supervision sessions. Staff also told us a spot check on their competency had been carried out by the branch trainer or one of the quality officers. Staff told us they felt supported. One staff member described how they used the on-call system to ask for advice from the office based staff and that they were really helpful. Three staff members told us the coordinator for the area they worked in was very supportive and good to talk to and they could call them anytime for advice.

Requires Improvement

Is the service caring?

Our findings

We received mixed views regarding the staff working for Westminster Homecare-Sheffield. These mixed views were also reflected in the feedback we received via the questionnaires. Some people made very positive comments about the staff in particular their regular workers. The positive comments made included: "the [care worker] is very good I've absolutely no complaints about privacy or dignity", "I have three regulars who are lovely I know all their names and I am absolutely happy with them. They are friendly and lovely and never overstep the mark and I do feel safe when they are helping me", "when they are here I do feel safe and some of them are very friendly indeed. I used to have a regular one, I like the older ones but whoever turns up is alright and they are okay with me but I don't stand for any messing you see love", "very nice people [care workers]", "the carers that come are smashing", "they [care workers] treat us with respect and they are good and efficient" and "they [care workers] treat you like their family".

People's mixed and negative comments included: "the young carers are not as caring as the older ones and cut corners to get away quickly. It is very nice to get the familiar face of a carer who knows their job thoroughly and does it happily for both persons involved. Some carers do not communicate well, it is a bit uncomfortable when a new carer comes and hardly speaks. It's easy and pleasant enough to chat about the weather", "some [care workers] are very good and some are mediocre, they don't talk to me, they talk to each other" and "the regulars [care workers] are very good, generally speaking new ones are amenable but one or two don't chat, the unpleasant ones".

We also received mixed views about the staff from relatives. One relative commented: "the regular lads [care workers] are okay and the others are not too bad but we prefer the regulars. They are all very caring and my [family member] is happy with them I would soon complain if he was not happy. They treat him with respect". Another relative commented: "most of carers are not carers in the true sense of the word, they are merely people who take up the job until something better comes along".

We shared the mixed views with the operations manager; they told us they would look at providing additional training for staff around interacting with people using the service.

People told us they did not hear staff discussing any personal information openly or compromising people's confidentiality. People's comments included: "never talk about anyone else" and "they [care workers] don't pass any remarks about anyone".

Staff spoken with told us they enjoyed working at the service. One staff member told us they were looking forward to getting their own route so they could get to know people better. Staff spoken with also gave examples of how they treated people with dignity and respect and maintained their privacy. For example, one staff member described how they were told about not discussing any clients with other clients and although clients ask about other people, they always move away from the subject so they don't share any information.

Requires Improvement

Is the service responsive?

Our findings

We reviewed seven people's care records. The registered manager told us that people's care plans should be reviewed on an annual basis or in response to a change in needs. For example, when the person's medication was changed. We found people's care plans and risk assessments had not been reviewed regularly. For example, one person's care needs assessment had been completed in December 2011 under the previous provider's name. Staff had contacted the person to complete telephone quality monitoring forms over the last five years. One person's care plan had been completed in November 2014, they had been due a review in 2015 but it was not completed until April 2016. We saw examples of telephone quality monitoring and home quality visits being completed. Another person's care plan had been completed in August 2014, a review date had been recorded for August 2015 but this review had not been completed. Whilst completing a home visit we saw the person's medication had changed since the last assessment. The registered manager informed us that staff were completing a review the following week for this person.

The registered manager had started managing the service in March 2015 and had identified that people's care plans needed to be reviewed. They told us staff had prioritised people's care plan and risk assessment reviews based on people's level of need and they had used telephone monitoring and home visits to identify those people. It is important that assessments are reviewed regularly for all the people using a service and whenever needed throughout the person's care to ensure it meets their needs. The operations manager told us that the provider was planning on employing an additional member of staff to complete people's care plan reviews and assessments.

We looked at two care plans that had recently been reviewed. Each person's care plan was person centred and their personal preferences had been reflected in their care plan. An account of the person, their life experiences, likes and dislikes and their religious and spiritual beliefs had been recorded in their records.

We found the provider had not ensured that people using the service received person centred care that was appropriate and met their needs. The provider had not ensured people's assessments were reviewed regularly or when their needs changed. These findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service had a robust complaints process in place to enable them to respond to people and/or their representative's concerns, investigate them and had taken action to address their concerns. Complaints were monitored via the registered provider's regular visits to the service. However, the feedback received from some people and relatives was the action taken to resolve the complaint was not always sustained. For example, an improvement would be seen for a couple of weeks or months and the issue would occur again.

Requires Improvement

Is the service well-led?

Our findings

Most people or relatives spoken with did not know who the registered manager was for the service. Some people or relatives could name a person they had spoken with but were not always sure about their role. We saw that people and/or their representatives had been regularly contacted by staff by telephone or a quality monitoring visit had been completed. We saw the action recorded in responses to any concerns noted had not always been completed but we saw this had improved in the telephone monitoring forms completed in 2016.

The service had sent a questionnaire to people at the end of 2015. We reviewed a copy a letter sent in February 2016 to people using the service which provided details of the action taken as a result of the survey. These actions included: new staff appointed at the office, staff to contact people when care workers are running late, the role of the field care supervisors who would be providing quality monitoring visits, telephone monitoring calls and care plan review visits each year in line with company and regulatory standards. It also included the contact details of the registered manager, and a copy of the updated complaints process. This showed the service actively sought the views of people using the service.

Care workers demonstrated a good understanding of the Westminster Homecare -Sheffield team of care and support staff. Staff also made positive comments about the senior managers at the service. The registered manager was visible and actively managing the service and was able to describe people's individual needs who used the service. During the inspection the registered manager and operations manager took action to address any concerns shared with them about people's individual care delivery.

The provider's operations manager regularly visited the service and provided ongoing support to the registered manager. The registered manager completed a weekly report for the operations manager to review. The report covered a range of areas and kept the operations manager up to date on the latest activity within the service. The areas covered included: complaints, accidents and incidents, missed calls and safeguarding alerts.

The provider's operations support manager completed checks at the service. We reviewed the quality audit completed in February 2016 which included an improvement action plan. The quality audit covered a range of areas including the following: staff training, care worker personnel files, monitoring of staff, medication audits, daily record logs, on call procedure, consent to care, quality monitoring, complaints, safeguarding, accident and incidents and missed visits. We saw evidence the action completed had been reviewed in July 2016.

However, during the inspection we found breaches in Regulation 9, Person-centred care, Regulation 12, Safe care and treatment and Regulation 13, Safeguarding service users from abuse and improper treatment. This showed the provider's systems and processes to assess and monitor the service to ensure compliance had been ineffective in practice. These findings evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service also provided regular reports to the local authority. The report covered a range of areas including the following: number of incidents reported, complaints, staffing, branch recruitment, safeguarding alerts and medication errors.

Office based staff told us staff meetings took place, which meant staff were provided with an opportunity to share their views about the care provided. The service had held a range of team meetings at the service since the beginning of 2016 including: care co-ordinators meeting, quality team meeting, call trackers meeting, finance meeting and branch meetings. Regular staff meetings help to ensure people received a good quality service at all times.

We reviewed copies of memos sent to care workers from July 2015 to the present time. The topics covered included adhering to rota times, the delivery of time critical calls, logging in and out of calls, the importance of confidentiality, the uniform policy and wearing ID badges.

We reviewed some of the provider's policies and procedures and saw these were reviewed on a regular basis to ensure they reflected current legislation. The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

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 Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. The provider had not ensured that risk assessments relating to the health, safety and welfare of people using the service were reviewed regularly.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected against the risks of financial abuse because the provider had not made sure they had robust procedures in place to make sure service users are protected.

Regulated activity	Regulation

Personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.