Solutions24 Limited

CareService24

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

The inspection took place on 11, 12 and 15 May 2017. We gave two days' notice of the inspection to be sure the registered manager would be available.

CareService 24 provides personal care and support to people who live in their own homes in Bournemouth and the surrounding areas. At the time of our inspection they were providing personal care and support to over 60 people.

The service had a registered manager, as required by law. 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.

At the last inspection in January 2016, we asked the provider to make improvements to how medicines were managed. Following that inspection, they sent us an action plan that stated the changes they would make in order to meet the regulation by 18 April 2016. However, at this inspection we found that medicines were still not managed safely. Responsibilities for ordering and administering medicines were not set out clearly in people's care plans. There were frequent occasions where people had run out of their prescribed medicines. Medication records were incomplete and staff did not always have clear instructions for how and when to administer prescribed skin creams or 'as required' medicines.

Some people's assessments and care plans did not clearly address needs that should have been identified and planned for. For example, care plans did not always mention significant health conditions such as diabetes. Consequently, there was no guidance for staff to provide the appropriate support and recognise when a person might be becoming unwell. There was not always sufficient, up-to-date information regarding people's moving and assisting needs.

Whilst the people we spoke with were positive about their care, others did not always get the care and support they needed.

The provider's quality assurance processes were not effective. Audits had not detected the significant issues we found in relation to medicines, care planning and delivery of care. There had been changes in office staff since the last inspection; the office had been fully staffed for only three weeks since the last inspection. Supervision and spot checks of staff had fallen behind. Complaints and safeguarding concerns had not been collated to identify themes for learning. Reasons for staff leaving employment were not systematically recorded and analysed.

People told us their staff were kind and compassionate. They said they were treated with respect and that their privacy and dignity were preserved. However, when we entered the flat of someone we were visiting they were in their bedroom with the door open, in a state of undress midway through personal care. The

staff who were providing care did not encourage the person to maintain their dignity. Some people could not recall having been asked about their preference for care workers of a particular gender and some said they would have liked a choice. The registered manager stated that gender preference was always asked at the start of a package of care but was unable to provide evidence of this.

Some people talked about having regular staff who knew them well, whereas others reported frequently changing staff. The service had recently updated their computer system to help the allocation of regular staff to people's care calls.

Some had had experiences with staff who arrived wearing dirty uniforms and smelling of tobacco. The registered manager told us they had already identified this as an issue and had addressed this with the staff concerned.

The staff we spoke with were positive about how they were supported. They were confident that they could approach the management team with any concerns and felt they had received suitable training to carry out their role. Staff training in essential areas such as moving and handling, medicines administration and infection prevention were up to date.

You can see what action we asked the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 were not always protected against the risks associated with the unsafe management and use of medicines.

The risks to people's health and safety whilst receiving care had not always been properly assessed and action had not always been taken to mitigate any such risks.

Staff knew how to recognise and report any allegations of abuse.

Staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had the right skills and knowledge, training and to perform their roles.

The registered manager and staff did not always act in accordance with the Mental Capacity Act 2005.

People mostly had the food and drinks they needed when this support was provided by the service.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their families felt staff treated them with kindness and compassion.

People's dignity and privacy was not always recognised and respected.

Staff did not always recognise situations where they were not supporting people to maintain their dignity and treat people with

respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had not had their needs met and other people were at risk of their needs remaining unmet, because care plans and assessments were not up to date and lacked specific information about people's needs and how they should be met.

The service had a complaints policy and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems were not effective and record keeping required improvements.

CareService24

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.

The inspection took place on 11, 12 and 15 May 2017. We gave two days' notice ahead of the first day, because the location provides a domiciliary care service and we needed to be sure the registered manager would be available. Two inspectors visited the office on 11 and 15 May, and one inspector telephoned people who used the service on 12 May.

Before the inspection, we reviewed the information we held about the service; this included notifications, questionnaires, online reviews of the service and information we had received from third parties including a local authority contract monitoring team. We did not request a Provider Information Return (PIR). The PIR 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 visited three people in their homes and spoke with four other people and a relative on the telephone. We also talked with a further relative, five care staff, four office-based staff, the registered manager, the nominated individual and a healthcare professional. We reviewed four people's care and medicine records in the office and the records in their homes, with their permission, of the three people we visited. We also viewed elements of a further person's care records. We checked records about how the service was managed. These included four staff recruitment and monitoring records, staff rotas, training records, audits and quality assurance records as well as a range of the provider's policies and procedures. The registered manager emailed us various policies and training information, as we requested.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy with the staff that looked after them and felt they were competent to provide the care and support they needed in a way that kept them safe.

At our last inspection in January 2016, we identified a number of shortfalls in the management and administration of medicines. There was a lack of clear instructions for topical medicines, such as creams and ointments, and these were not recorded in people's medicines administration records (MAR). MAR were handwritten by staff, but had not been signed by the person who created them and someone who had checked they were correct. Following the inspection, the then registered manager submitted an action plan that identified the work needed and confirmed the service would meet the regulation in relation to medicines by 18 April 2016.

At this inspection we found that any improvements that had been made had not been sustained and further issues were also identified.

CareService24 did not have appropriate arrangements in place in relation to the administration and recording of medicines. The medication policy and procedures did not reflect national published guidance or relevant local authority policies about how to ensure medicines were handled, stored and administered safely.

The CareService24 medication policy stated there should be a medication care plan for each person who received support with their medicines. None of the care records we looked at contained medicines care plans.

Responsibilities for ordering, collecting and managing medicines and the action to take if people ran out of medicines were not clearly set out in the general care plans that were in people's files.

There were a number of occasions where staff had reported that people were either running out of medicines or had run out but there was no evidence the service had taken appropriate action to ensure new supplies were obtained. One person did not have their prescribed topical creams for 11 days and another person went without their pain relief for more than one day. We cannot say for how long they were without this medicine because the medicines administration record (MAR) was not properly completed.

MAR were created from care records held in the office and sent to each person's home for staff to use from the start of a four week cycle. Some of the records showed people had been prescribed additional medicines part way through the cycle. In this situation, staff had handwritten the new medicine onto the MAR but there was no evidence that other staff had checked this had been transcribed correctly and there were no staff signatures. In addition, there were occasions where the quantity of a medicine on the pre-printed MAR had been changed. The new dose had been written in by hand but had not been dated or signed and it was not possible to establish why or when the medicine had been changed. We also found there was often no entry on the MAR to show whether an item had been administered, offered and refused

or not given for another reason. This meant we could not be sure people were receiving their medicines as they had been prescribed.

Four people had skin conditions and had been prescribed topical creams to treat these. The CareService24 medication policy stated staff should only administer topical creams following an assessment and creation of a care plan to instruct staff. There were no assessments or care plans for any of the topical creams that we checked. The MAR for each person stated the name of each cream but not always where it should be applied. There was no guidance in place to ensure staff applied the correct amount or followed other requirements, such as leaving on the skin or rubbing into the skin. This meant people may not have received some of their medicines as prescribed.

Staff had been trained in the administration of medicines and their training was updated annually. Their competence in administering medicines should have been assessed during unannounced spot check observations by more senior staff whilst providing care. This would help ensure they were following the correct instructions for medicines and keeping suitable records. However, these checks had fallen behind, although the service planned to resume these. At the last inspection, we reported that spot checks had not been prioritised and that there was an action plan in place to reintroduce them. Following this inspection, the registered manager told us the medicines competency assessment document had been revised and competency assessments had been re-started.

Some medicines were prescribed in variable quantities. The actual amount administered was not clearly recorded on the MAR and there was no information about the maximum amount to be given within a fixed period of time. This meant that people may be at risk of receiving too little or too much of their medicines and that they may not receive some of their medicines as prescribed.

Some people had been prescribed medicines on an 'as required' basis (also known as PRN). There was no assessment or care plan to guide staff on when to administer the medication, how much to give or information on the maximum amounts to be given within a fixed period. The CareService 24 medication policy stated there must be a specific care plan for the administration of PRN medicines. However, none of the records we saw contained care plans for PRN medicines. For example, one person was prescribed paracetamol 'as required'. According to the MAR, some staff had administered the medicine at every visit but there was no record as to why it had been given. Other staff had not recorded if paracetamol had been offered and subsequently refused. This meant that people were at risk of receiving too much medicine and that they may not receive some of their medicines as prescribed.

One person lived with a number of allergies to foods, materials and medicines. This information should have been recorded on the MAR to ensure staff were aware. The most recent MAR did not include all of the person's allergies. This meant staff did not have clear information about the person's allergies and the person may have been at risk of exposure to such items.

Another person lived with a number of complicated health issues. Their medicines were administered by staff at all visits. There was no care plan for the medicines and no information about the minimum or maximum amount of time between doses. Staff were often making calls to the person either earlier or later than shown on the rota. This meant the person may not have been having their medicines are the correct times and this could have affected the effectiveness of the medicines they were taking.

The CareService 24 medication policy stated homely remedies should only be given by staff if this had been assessed, planned for and confirmed with the person's GP. There were no homely remedy assessments or care plans in the documents we examined. There were entries in daily records that showed staff had

administered homely remedies such as topical creams and laxatives without following the policy and procedure. This meant staff could not be certain that it was safe to administer these items to the people concerned.

These shortcomings in relation to medicines were a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

There were systems in place to manage risk but these were not operating effectively. There were a number of different risk assessment forms in use. These included people's home environments that staff worked in, as well as risk to people from falls, developing pressure sores, malnutrition, and the use of specific items of equipment. The completion of the forms lacked consistency; some risk assessment forms had been placed in people's files but not fully completed. Some had been completed and had identified risks but no action to manage the risk with appropriate control measures or support from other professionals. For example, one person had been assessed in October 2016 to be at 'very high risk' of pressure sores. There was no evidence that any action had been taken to reduce or manage the risk. The assessment had not been reviewed. Staff had made recent entries in daily records that the person had developed pressure sores. One of the topical medicines that had not been available was to protect this person's skin from breaking down and forming pressure sores.

One person we visited was a smoker. Risk assessments in relation to the person's home environment were out of date. An entry in a visit record referred to them putting themselves at risk by smoking in bed. The registered manager had reported this to other agencies but had not completed their own risk assessment or sought advice from the local fire service. This was of concern as some of the topical creams the person used could be flammable. We raised this on the first day of the inspection. When we returned for the last day of inspection, no action had been taken to address our concerns and the person had continued to be left at risk. Following the inspection, the registered manager informed CQC that they had taken measures to ensure people and staff were aware of the dangers of smoking and using high paraffin content creams and had contacted the local fire service

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Some people had items of equipment such as hoists to help them transfer from their bed to chairs or other items of furniture and equipment. The service had not carried out risk assessments to ensure the equipment was fitted and worked safely and that any risks either to the person or staff were identified and managed correctly. One person had a special bed with rails fitted. A risk assessment had been carried out in October 2016. This had not been reviewed and there were no records to evidence that staff checked to make sure the equipment remained safe to use.

One person sometimes asked staff to purchase small items such as snacks and drinks for them. Staff kept a record of the date they did the shopping, the amount of money given to the care worker, the amount spent and the amount returned. The care worker and the person both signed the record and receipts were kept. However, there was no system in place to check records and receipts or to ensure the amounts were correct. This meant that there was no system in place to protect either the person or the care worker.

These shortcomings in relation to risk assessment and management were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an out-of-hours on call system for people who used the service and staff to contact senior staff in emergencies or for support in various situations. People and staff confirmed the on call system worked well should they need to use it. Most said calls were answered or returned promptly.

The registered manager told us accidents and incidents were currently monitored for each individual person using the service, and that there were plans to introduce a monthly report of accidents and incidents across the service in order to identify patterns and trends. This was an area for improvement.

The registered manager had developed a draft emergency contingency plan, but this was not complete. The development of an emergency contingency plan was in progress at our last inspection. The registered manager and a care co-ordinator were able to explain how they would prioritise care calls in an emergency. They showed us how priorities, such as time-critical visits, were flagged on their computer system.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. The service's safeguarding adults policy had been updated in 2016 to reflect changes in the law relating to safeguarding adults.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Criminal records checks had been made with the Disclosure and Barring Service (DBS) to make sure candidates were suitable to work in a care setting. Records seen confirmed that staff members were entitled to work in the UK. A member of staff who had started in recent months told us they had not been allowed to begin work before their DBS check had been completed.

There were sufficient staff with the right skills and knowledge to meet people's individual needs. People told us a care worker always turned up to provide their care and stayed for the full length of the visit. The registered manager confirmed there were sufficient staff to provide care. One person commented that punctuality had improved in recent months: "An odd slip up with times but much better now than it was". There was a computerised system for monitoring any calls that needed to be covered; it showed that calls for the coming weekend had been covered. Missed visits were detected through people or relatives reporting these themselves or through checks of timesheets as they were returned to the office each week. There were 10 missed visits on file from September 2016, the most recent being recorded in February 2017; this is a very small figure in comparison with the number of calls scheduled in that period. The service was developing an automated method of monitoring whether calls were happening on time by staff checking in electronically at each visit, but this was not operational at the time of the inspection.

Travel time was allocated between calls and the management team confirmed staff were reimbursed such that their pay exceeded the minimum wage. Calls were mostly organised within local areas to minimise the distance travelled, although if staff were covering an absent colleague they might travel from further afield. Staff told us they generally had enough travel time unless there were unforeseen circumstances such as a traffic accident. However, one person told us they did not think sufficient travel time was allocated. They commented, "I do find they're not given enough travelling time" and said that staff sometimes appeared to them to be stressed because of this.

Requires Improvement

Is the service effective?

Our findings

People and their relatives said staff were skilled and capable to meet their needs. For example, a relative told us, "The carers that come in are really good". One person commented that a member of staff a while ago had tried to assist them to bed whilst they were still wearing shoes and did not have their nightwear on, but said they were generally pleased with the staff.

People received care from staff who had access to much of the training they needed. Staff had received training that included health and safety, infection control, and medication. Staff had not all had training about their responsibilities in relation to the Mental Capacity Act 2005. Following the inspection, the registered manager confirmed that a training programme had been put in place.

Staff told us they had the training they needed when they started working at the service, and were supported to refresh this as necessary. Training in moving and assisting people was provided in house by a trainer who had a current qualification to teach this. Most other training was provided online or via distance learning. Staff had opportunities to work towards qualifications appropriate to their role, including the Care Certificate for new staff and nationally recognised diplomas in health and social care.

Staff told us they were supported by the management team. They said they had supervision meetings with their line manager which enabled them to discuss any training needs or concerns they had. The service had identified in their improvement action plan that supervision had fallen behind due to a shortage of supervisory staff and was taking measures to address this. Staff visited the office during the inspection for supervision.

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

People's consent was sought to confirm they agreed with the care and support provided. People and relatives confirmed that staff always checked with the person before providing care and gained their consent to provide the care needed. Three of the care plans contained consent forms that had been signed by the person using the service. One consent form had been signed by a next of kin or relative although there was no evidence in the records that the person had a Lasting Power of Attorney for health and welfare and therefore had the legal right to do this on a person's behalf. There was no record of the reasons why the person had not signed the consent form themselves and a mental capacity assessment or best interest decision about this had not been made. We reviewed the care records for one person who was cognitively impaired to the extent there was concern about their ability to consent to their care. The previous registered manager had undertaken a mental capacity assessment, which concluded the person lacked the mental capacity to consent to their care, and, having consulted with the person's relatives, had recorded a best interests decision in relation to this. The service had a consent policy; however, this contained inaccurate

information about sources of information and guidance for staff. This was an area for improvement.

People who were supported with meals and food told us they were satisfied with the support they received.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us they received a caring and personal service. They said there was a core group of staff who they felt they knew and who knew them. They also said they were always informed before new staff would be caring for them. They told us the staff who visited them were kind and caring. Comments included: "I can't fault them. They're extremely patient and very forbearing", "I must say they're most patient and kind", and, "On the whole very helpful, very good and very cheerful". They told us staff asked them how they liked their care to be provided and that, if they wanted their care completed in a particular way, staff would listen to them and respect their preferences.

People told us they were treated with respect, and that their privacy and dignity were preserved during their care. The staff we spoke with recognised the importance of this. However, when we entered the flat of someone we were visiting they were in their bedroom with the door open, in a state of undress midway through personal care. The staff who were providing care did not encourage the person to maintain their dignity.

People gave mixed responses about whether they were asked if they minded having staff of either gender providing their care. Some people remembered being asked whether they had a strong preference. One person said they had been asked if they would mind having carers of another gender for calls at a time of day when they had less intimate care, but then found this happened at other times too. They had raised this with the office and thought their preference was now being respected. Others could not recall being asked. One person said they would have preferred a particular gender had they been given the choice. Someone else told us they had got used to having workers of another gender, although this had not been their original preference. The registered manager stated that gender preference was always asked at the start of a package of care but was unable to provide evidence of this.

The shortfalls in relation to maintaining privacy and dignity and gender preference were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people received care and support from staff who had got to know them well. They said they had a consistent team of staff whereas other people told us they frequently had new or different staff visit them. For example, someone expressed their frustration that just as they got to know new staff these staff left. They said that continuity of staff went through periods of being good and not so good. Staff reported they had worked with the service for a few years and visited a consistent group of people, whom had got to know. They were able to give a clear account of how these people liked to be supported.

The registered manager and staff we spoke with were aware of people's preferences, likes and dislikes, although assessments and care plans did not always reflect the detail that the registered manager or staff were aware of. This meant not all staff would be able to provide the same level of care because they did not have sufficient information in the care plans. This was an area for improvement.

People received information when they began to receive a service. Rotas were sent out each week setting

out what time people's care calls would be and which staff would be attending them. Some people said their rotas were reasonably accurate, but others reported frequent changes. One person told us of the rotas they received, "Never the same by the time the day comes round… Almost like they're firefighting all the time", although they said their calls were always covered. People told us they were mostly informed of rota changes.

All of the people and relatives we spoke with confirmed that they had been consulted about their care plans and were involved in making decisions about their care. They also said their needs were met by the staff that visited them.

The staff we spoke with knew about requirements to keep people's personal information confidential. People confirmed that staff did not share private information about other people with them.

Requires Improvement

Is the service responsive?

Our findings

People were positive about their care. They said their service was reliable and they did not worry about being let down. Comments included: "Everything gets done and they [care staff] follow [our] instructions… There is a care plan in place but are they [staff] given time to read it?", "Very helpful and very good, "Very happy with them overall… if there's anything wrong I would tell them", and "I think the care is wonderful".

Whilst people gave good feedback about the care they received, we found shortfalls in assessment and care planning. All of the care plans we looked at contained omissions or inaccuracies, either because initial assessments had lacked detail or because people's care needs had changed.

People's care needs were not always fully assessed and planned for. One person had a pressure sore but there was no assessment of this, nor a plan for staff to follow to prevent further deterioration or promote the healing. There was no record of actions taken such as contacting the community nursing service. Someone else had very specific moving and assisting needs due to the amputation of a limb. There was no reference to the amputation in any of the documentation held in the office and neither the documents in the office or the person's home contained a moving and assisting care plan. This was also the case for another person who required two staff and equipment to help them to mobilise. This meant staff may not have all the information they needed to provide the care that was required.

Two people lived with diabetes. There was no care plan outlining what the condition meant to the person, how it affected them, how it may progress and any risks such as high or low blood sugars, the signs and symptoms of hypo or hyper glycaemia or other possible complications. There was also no information about the medicines people took to manage their condition or whether the timing of support visits and meals was important in managing the condition. Visit records showed a variation in the times that staff arrived for visits for one person. Notes showed that the person had often already made their meals although the care plan stated that staff should do this. It was not clear whether the person required support with meal preparation due to their diabetes and whether this must be done or was only needed if the person had not done this themselves or requested support.

Another care plan stated that a person should have assistance every morning to have a shower. There was a brief statement that the person may often be dressed when staff arrived and were often reluctant to accept support. The care plan instructed staff to spend time with the person and reassure them so that they would then accept support to shower. Analysis of visit records for the month of April 2017 showed the person had showered only once. Over a fifteen day period there were six occasions where it was recorded that the person was supported to wash and eight occasions where staff had accepted a refusal or no entry was made regarding personal hygiene. Where a refusal was accepted by staff, it was not clear whether they had followed instructions in the care plan before accepting this.

These shortfalls in relation to care planning were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they would feel able to complain to the service. The registered manager was unable to tell us how many complaints had been received since they came into post. They told us there had been no complaints that warranted investigation other than matters they had notified to CQC. The service had a complaints policy that specified how they would handle verbal and written, informal and serious complaints. This included the timescales in which they would investigate and respond to the complaint. People confirmed that they knew how to complain and felt they would be confident to do this should the need arise.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were positive about their experience of care but had a mixed experience of communication and administration. A person named the registered manager as being thorough and said there was always someone there to take a message if they rang in. Others said this let the service down. Comments included: "What I've raised is more of a management issue… The people on the ground are great. It's just the office staff who let the side down" and, "Communication is a bit dire". One person noted that in the past the office had not dealt with them efficiently, although more recently this had not been a problem.

There were arrangements in place to monitor the quality and safety of the service provided. There were audits of various areas including medication, infection prevention and control, accidents and incidents, care plans, complaints and health and safety. However, these were not fully effective. Recent audits of care records had failed to identify the significant shortfalls we found in relation to medicines and to care planning and delivery. For example, audits of care plans and visit records had not identified that people had needs such as pressure area care, diabetes, personal care and moving and handling that had not been assessed and planned for.

Audits of medicines administration records had not highlighted that people's names and allergies were not always recorded, or that there were numerous occasions where no record had been made so that it was not possible to know whether the person had received their medicines as prescribed. Audits had also not highlighted that staff had administered homely remedies to people without following correct procedures.

There were occasions where staff had written inappropriate comments in the visit records and care plans, such as referring to someone's personal financial situation or stating that a person was 'snoring loudly', rather than just stating that the person was asleep.

All of the records referred to had been audited by a member of the management team and no comment or action had been made about them. This meant the registered manager was not aware of the issues that we highlighted during our inspection.

Other quality assurance processes, including staff supervision and spot checks, had fallen behind because there had been a high turnover of office staff and vacancies had not all been filled until very recently. One person told us they had been with the service for several months but not had anyone from CareService24 check they were satisfied with the service they received.

Feedback was not systematically obtained from staff and used to improve the service. Whilst quality assurance surveys had been sent out during the year, there had been no staff survey since the last inspection. We had been told at the previous inspection that a staff survey was planned within the next three months. There had been meetings for different groups of staff in September and October 2016; the previous meeting had been in November 2015. Staff who left had an informal exit interview but the findings were not collated in order to identify improvements that could be made to the service.

Complaints and safeguarding concerns were treated as individual incidents. They were not collated and analysed to identify themes and areas for learning.

These shortfalls in quality assurance and the oversight of staff were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Someone told us how they had asked for a care worker who turned up in a dirty uniform smelling of smoke to be taken off their rota. They said this had happened eventually, after there had been a change in the office coordination staff. There had been a separate complaint about staff smelling of tobacco. This was raised at the staff meeting, along with themes from other complaints.

People's experience of care was monitored through quality assurance surveys sent out during the year. These were returned to and analysed by a third party company. From the most recent survey in August 2016, eight people had submitted positive feedback and five people had described areas for improvement. The management team had reflected on possible reasons for reduced scores and adverse comments, and had identified that there were challenges facing the service. These had been addressed in the ongoing service improvement action plan. For example, care calls in some areas had been organised as regular 'runs' to help improve continuity of staff.

The registered manager had notified CQC about significant events. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

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 Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with respect and dignity at all times while they are receiving care and treatment.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

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 the unsafe management and use of medicines.

The enforcement action we took:

A warning notice was issued.