Mrs Carol Jackson

Bronte Care Services

Inspection report

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Tel: 01274550966

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Our inspection took place on 11 and 12 July 2017 and was announced. This meant we gave the service a short amount of notice of our visit to ensure a manager would be present in the office. This was the first inspection of the service since they became a newly registered service due to a change of registration in June 2016.

Bronte Care Service provides personal care to people in their own homes in Bingley and the surrounding areas. At the time of the inspection there were 95 people using the service.

The registered provider is a single provider and therefore manages the service on a daily basis. 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.

Medicines were not managed safely. We found a number of discrepancies where we could not confirm whether people had received their medicines as prescribed. Where medicines had been left out for people to take later, this had not been recorded in a clear way.

We saw a high number of missed calls. This indicated people who used the service had been put at risk of harm from these missed calls. People told us they were not happy with the service due to the lack of continuity with their care workers; in that care workers were often changed and the service did not let them know about these changes. Staff told us they did not have travel time so they were always running late. People told us and we saw a record of a number of late or short calls which meant people's individual needs were not met.

People told us they felt safe receiving care and support from the service; however, we found risk factors were not well documented. Risks associated with people's care and support were not always consistently documented and was not used to produce meaningful guidance to staff to help minimise those risks.

People told us staff were generally kind to them and treated them with dignity and respect. They said staff were well trained to carry out their role. People were supported by staff who had received induction training which included shadowing more experienced staff. We looked at the provider's training matrix. This is a document which lists training staff have received and the dates completed. This showed staff received training in a number of subjects.

We saw recruitment was safely managed to ensure staff were suitable to work with vulnerable adults. However, we found staff did not always receive regular supervision and annual appraisals.

The provider told us there were sufficient staff employed to enable the service to provide care and support to people. However, we found rota's had no travel time and calls were unreliable. Staff were not always deployed in the right places at the right time.

Staff told us the provider conducted regular unannounced spot checks to make sure they were doing things correctly. They said they came unannounced and checked their working practices such as how they speak to people, how they completed care plans and whether they moved people safely. However, we found some staff members had not had a spot check for several months.

Staff told us that care plans were usually kept up to date but said if there was a change to people's needs it would sometimes take weeks for the care plan to be updated. One staff member told us, "Office staff should improve communication, such as letting carers know about changes more promptly."

People told us they were happy with the support they received to have a healthy diet. Staff were able to recognise and report when people's healthcare needs changed.

The service had systems in place to deal with concerns and complaints. However, some people told us complaints had not been appropriately managed and complaints had not been consistently recorded.

We did not find adequately robust governance systems in place. Audits were not comprehensive or meaningful and the service did not always respond to concerns raised.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities)

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.

Systems to ensure the safe administration of medicines were not effective.

People who used the service had been put at risk of harm from missed calls and risk assessments did not provide sufficient information.

We saw recruitment was safely managed to ensure staff were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

The records we looked at showed not all staff were receiving regular supervision as stated by the provider. We also found staff annual appraisals were not up to date.

Where people lacked the capacity to make decisions relating to their support there was a lack of evidence of capacity assessments and best interest processes followed.

People told us they were happy with the support they received to have a healthy diet and had support to gain access to healthcare professionals.

Overall, staff received a thorough induction with training and shadowing opportunities.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity.

People told us there was a lack of continuity with their care workers and the care staff were always running late.

Staff had developed good relationships with the people who used the service and used their knowledge of people to provide person centred care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always provide accurate detailed information about people for staff to be able to provide individualised care.

People often did not receive their agreed amount of care and support. This meant staff were rushed and did not always complete all care tasks.

There were systems in place for dealing with complaints and concerns. However, people said complaints had not been appropriately managed.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

The provider did not have effective systems in place to monitor the quality of the service they provided.

Some people told us that when they raised issues with the office they were not always dealt with promptly.

We found a number of discrepancies with care and support plans which should have been identified and rectified through robust quality assurance systems.

Staff said they enjoyed working at the service and they received good support from the management team.

Bronte Care Services

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 and 12 July 2017 and was announced. We gave the provider 48 hours' notice as they provide a domiciliary care service and we needed to arrange for someone to be in the office to speak with us.

The inspection team consisted of three adult social care inspectors and an expert-by-experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. Their expertise was in supporting an older person using care services.

Before the inspection we reviewed all the information we held about the service, including notifications from the provider, information from the local authority and the 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. The service returned this in a timely manner and we took this into account when making our judgements.

At the time of our inspection there were 95 people receiving the regulated activity of personal care from the service. During the inspection we used various methods to help us understand the experiences of people who used the service. Before our visit to the service office we spoke with 13 people who used the service and eight relatives on 11 July 2017.

We visited the service office on 12 July 2017 and looked at elements of eight people's care records, medicines administration records (MARs) and other records which related to the management of the service including quality assurance processes, policies and procedures. We spoke with the provider, two care co-ordinators and four care workers. We also spoke on the telephone with six staff.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe receiving care and support from staff but there were many issues regarding continuity and reliability. One person said, "I had one or two missed calls, they muddled it up in the office nothing serious. I can dress myself so I'm not waiting for them to do that." Another person said, "I feel safe I have no concerns. I'm a retired pharmacist so I manage my own medication."

In the PIR the provider told us, 'We have an electronic call monitoring system which enables us to see whether calls are being done as carers have to log in when attending calls'.

We saw a concerning high number of missed calls had taken place since February 2017. The electronic record given to us by the provider showed 65 calls had been missed. We found a lack of investigation into missed calls, incidents or accidents. In one person's daily records it was written "Why has nobody been to see my mum tonight, I had a call from safe and sounds at 2.30 saying mum was shouting for me, came down and found her on the floor." This should have been raised as a safeguarding alert by the service. After the inspection a safeguard was raised by the service.The manager said this call had been missed. This was not written up on an incident form and there was no investigation of this incident to determine whether the missed call had contributed to the person being found on the floor. We saw this person had experienced another missed call nine days earlier. In another instance which was being dealt with through the Local Authority's complaints process, a missed call had occurred following the person's discharge from hospital resulting in a lack of an evening call for the person. The person had to be admitted back to hospital the next day. It was currently being investigated by the Local Authority as to whether the missed call was a contributing factor.

We concluded the above evidence indicated a breach of Regulation 12 (1) (In safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A medicines policy was in place and staff had received training in medicines management. Some people had a medicine profile in place which stated the level of support that person required with their medicines and who was responsible for ordering their medicines, however, this document was not consistently in place or up-to-date.

The service made up its own Medicine Administration Records (MAR) transcribing information from the prescribers onto printed MAR charts. MAR's detailed the individual medicines people were prescribed and were in many instances well completed. However, this was not consistently done; we found a number of discrepancies where we could not confirm whether people had received their medicines as prescribed.

We saw handwritten entries had been added to one person's MAR chart. These did not always contain full details of the dose or number of tablets. The person had also been prescribed antibiotics; however, the administration of these was not always recorded or set out in a clear way on the MAR chart. This meant we could not confirm the person had received their medicines as prescribed.

Another person was prescribed paracetamol to be given four times a day at four hour intervals. It is important that paracetamol is given no more frequently than this. However, call times to this person were erratic and not conducive to giving these medicines at the appropriate intervals. We saw instances where staff had signed to state they had given paracetamol just two hours apart. For example, in one instance it was signed as given at 17:11 and 19:13. On another occasion the person's relative had signed to say the medicines including paracetamol were given at 17:35 and staff had also signed to say the next dose was given at 18:40. This person's records showed support with their medicines was provided by both care staff and the person's family. However, there was no clear written agreement in place detailing the level of responsibility of each party. This is a requirement of the National Institute for Care and Health Excellence (NICE) 'Managing medicines for adults receiving social care in the community. This demonstrated unsafe management of medicines.

We found information recorded in people's daily records and MARs did not match. For example, one person's daily records highlighted they were asleep so medicines were not given, but the MAR was signed stated they were given. On another occasion, their relative had written in daily records that medicines were found by 'the side of bed,' but the MAR chart was signed as medicines administered. Another person's daily records showed one evening they had run out of their medicines and staff had not been able to administer them. Daily records showed staff had gone to the pharmacy the next day to pick up the medicines. However, the MAR chart had been signed as given, despite them being out of stock.

Where medicines had been left out for people to take later, this had not been recorded in a clear way on the MAR chart. This demonstrated unsafe management of medicines.

The manager told us another person did not receive medicine support from care workers and as such there was no MAR in place. However, the daily records showed medicines recorded as given by care staff on a number of occasions. This showed a lack of appropriate record keeping.

We concluded the above evidence indicated a breach of Regulation 12 (f) & (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessment documents were in place. However, these were not always updated and did not provide sufficient information. For example, one person's manual handling risk assessment did not provide sufficient information on how staff should safely transfer them between various areas of their home. In another instance, the manager and care co-ordinator explained how a person had complex handling needs and needed two carers to mobilise. They said the Occupational therapist was involved. However, there was no manual handling risk assessment in place. This was put in place during the inspection but it meant that the person had been receiving care and support without adequate assessment and no plan of care for staff to follow. This showed the risks to this person had not been properly assessed. Other risk assessments were not kept up-to-date when people's needs changed.

We concluded the above evidence indicated a breach of Regulation 12 (2) & (a) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us visits had been missed in the past; usually at weekends. The relatives we spoke with told us no harm had come to their family member as they had provided the care needed. However, they were not happy to do this. They said apologies and explanations were given for the missed visits and one person said, the agency had "upped their game" recently.

One staff member told us, "The main thing I would improve is to add travel time on the rotas as at present

this isn't done which can cause problems and delays. The lack of travel times makes things stressful as it feels like we are constantly rushing. The main problems arise when additional calls are added onto our regular run. For example, if someone calls in sick or there is an emergency this means we often have to travel quite a way out to a different geographical area which then throws you out for the rest of the day. That seems to happen a lot on Saturday mornings."

Rotas contained no travel time and we saw evidence visits were regularly cut short. This meant that staff were not deployed in the right places at the right time.

We concluded the above evidence indicated a breach of Regulation 17 (In good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they did the same visits each week which meant that they could get to know people and their needs. One staff member told us, "I always do the same run so I know the people I care for really well now. It's usually the same staff on the run so people get the same carers each week which I think is really good." Staff told us they usually go to people at the same time each day and if they were going to be late they would call to inform the person they would be late.
However, some of the staff we spoke with told us they were not allocated regular visit runs, which meant people did not always receive consistent care. One staff member told us, "I go to different people every day so I can't get familiar with the people I care for. I have had occasions where I have turned up and not known the person at all so I have to spend additional time reading the person's care plan and hoping it is up to date and that the person can tell me what they need."

Staff told us where people required two staff members to help them move there were always two staff members allocated for these visits. One staff member told us, "There has always been a second person for the double up calls; I have never had to do those calls by myself. Sometimes the other carer may be late if traffic is bad but we have mobiles and contact each other so I usually know they are running late and can let the person know we may be late."

We looked into how people who used the service were protected from abuse. Staff we spoke with told us they would report any sort of abuse straight away and they were aware of the different types of abuse. Staff were able to explain who they would report concerns to and were also aware of whistleblowing. One staff member said, "They are always on to us to report anything we see."

We saw recruitment was safely managed to ensure staff were suitable to work with vulnerable adults. Records showed all the required checks were carried out before new staff started work. This included two written references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency which holds information about people who may be barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions. Some of the staff we spoke with had only been working for the service for a few months. They told us the provider had completed thorough recruitment checks prior to them starting work, such as obtaining a DBS check and references.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they had confidence in the staff who visited them or their relatives. One person told us, "They are well trained; they know just what to do. I have no concerns around that." A relative said, "They are well trained. They all know what they are doing."

When staff are initially employed by the service, an induction process was commenced. This included online learning, service specific training and shadowing experienced staff.

In the PIR the provider told us, 'We have a traffic light system for staff training, if a course is up to date it's green, if it is coming up for renewal then its yellow and if it has expired its red. Where possible staff will be asked to attend training while they are on yellow.'

We looked at the provider's training matrix. This is a document which lists training staff have received and the dates on which the training was completed. This showed staff received training in subjects including dementia care, infection control, moving and handling, safe administration of medicines, mental capacity and other relevant training. We asked the provider what plans they had in place to ensure training was kept up to date and refreshed at regular intervals to help ensure staff remained effective in their roles. The provider showed us dates of training staff were booked on for refresher courses.

Staff told us they received a variety of training on key topics such as moving and handling, safeguarding, basic first aid and dementia. New staff told us they received an induction which included training about the organisation, training on key topics and then a period of shadowing shifts. One staff member told us, "I had a good induction, which included training on key areas such as moving and handling and safeguarding. I then shadowed for three weeks before I worked by myself."

The provider told us staff were scheduled to receive quarterly supervisions. New starters received more intensive support during the first few months of their employment. The records we looked at showed not all staff were receiving supervision as stated by the registered manager. We also found staff annual appraisals were not up to date. The provider told us they were working on this. Supervision and appraisals gives staff the opportunity to discuss any support they might require to enable them to carry out the duties they are employed to perform.

One staff member told us, "Staff from the office do regular unannounced spot checks to make sure we are doing things right. They come unannounced and check our working practices such as how we speak to people, how we complete care plans and whether we move people safely." However, other staff members told us they had not had a spot check in some time.

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

possible.

People we spoke with told us how staff asked for their consent to care and support and how they offered them choice. One person said, "They always ask permission before doing anything." Another person told us, "I make my own choices."

Care records had been signed by people and/or their relatives to show agreement to plans of care. However, where people lacked the capacity to make decisions relating to their support such as medicines, we saw a lack of evidence of capacity assessments and best interest processes followed.

Staff told us they used care plans but were guided by what each person wanted during each visit. They said they would always ask people's views about how they would like their support to be delivered because they recognised this could change from day to day.

Staff told us that people's needs were detailed in their care plan, a copy of which was kept in the person's house. Staff told us that care plans were usually kept up to date but said if there was a change to people's needs it would sometimes take a while for the care plan to be updated. However, staff told us usually staff from the office would call them to inform them there had been a change. One staff member told us, "Office staff should improve communication, such as letting carers know about changes more promptly. This doesn't happen often but it is important that we have the right information when caring for people."

We found people's relatives mainly dealt with people's healthcare appointments, although staff told us if people needed to see a GP or became unwell during their visit then they would call either a GP or an ambulance and would stay with the person until help arrived. One staff member said, "I would take prompt action and never leave someone on their own."

People told us they were happy with the support they received to have a healthy diet. One person said, "They do healthy choice, adequate portions and they make a cup of tea." Another person said, "Very good. I have a different meal choice every day."

Care records assessed people's needs with regards to eating and drinking and care plans, where updated, provided information on the support to provide. However, call times were not always conducive to effective mealtime support. For example, we saw one person received their breakfast call at 10.30, where staff prepared breakfast. They then returned at 11:30 to make the person's lunch.

Requires Improvement

Is the service caring?

Our findings

People spoken with told us the care workers were kind. One person said, "Yes, they chat a bit, they just come and do the job and go." "They listen to me and ask what you want now and again." Another person said, "They are respectful and pleasant." "They are flexible and ask me what I want."

Staff gave us examples of how they helped to maintain people's privacy and dignity, such as closing doors and curtains when supporting people with personal care. Staff told us they were mindful they were entering people's private home and gave examples of how they ensured they respected people's personal property and space, such as knocking and introducing themselves before entering.

In the PIR the provider told us, 'All staff are trained in effective communication and have skills in non-verbal and verbal communication.'

One family member said, "They are very warm and friendly, if they want to do something different they consult with us." Another family member said her mother in law enjoyed chatting with the carers and enjoyed their company.

We asked people if the carers respected people's privacy and dignity, one person said, "Rather better than that, on a more friendly level, mutual respect. The girls chat, I know all about their grandchildren."

One person said, "If I'm concerned about anything I let my carer know and she is very polite, really good, I'm happy with what I get, I want it to carry on as it is with her, and I've built a confidence with her."

Another person said, their regular male staff member was, "A very intelligent fellow, lots of interests and good conversation. They are very good if we change the times, we are involved in making decisions."

One person said the staff were "All nice, we talk about all sorts." They said their care plan had not been reviewed for some time but still met their needs. They said the service would sort out any issues and they didn't need to contact the office.

One family members said, "The staff are kind, no problem there, some more chatty than others he [the person receiving care] enjoys their conversation, we are always having reviews."

Some people told us they were not happy with the service due to the lack of continuity with their care workers; care workers being changed and the service not letting them know and in addition care workers not having travel time so were always running late. People said, "No I am not happy with them at all. I think they are not properly organised. It is telling on them and on their customers. They change the visit times and the carers and they don't tell you. If they only just phoned you to tell you. It seems they don't care about you and it's just about profit."

We found there was a lack of information recorded in files about past lives and experiences to help staff

understand the person and provide highly personalised care.

We saw daily records provided some evidence people were listened to and asked consent before care and support was offered. We saw evidence people's right to refuse care and support was respected and recorded by care staff.

Staff told us they sought opportunities to encourage people to maintain their independence where ever possible. For example, one staff member described how they were encouraging and helping one person to improve their mobility so they could walk again. They told us, "We feel this is a goal we really want to help support them to work towards as it would really help them to regain their independence and confidence."

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider told us, 'All care plans reflect a person centred approach to care to ensure their individual choices are respected. Care is delivered in line with service user's lifestyle.'

People's care needs were assessed prior to using the service. This assessed their needs in a range of areas including medicines, food and nutrition, mobility, and their likes and preferences. These were then used to develop a step by step care plan instructing staff of what to do at each visit. However, care plans and risk assessments were not always kept up-to-date and as such they did not always reflect people's needs. For example, one person's care plan had not been updated since 2015 and contained no reference to the need for an earlier call on certain days because they attended a Day Centre.

Where people's care packages changed, care plans were often not updated. For example, another person did not have an up-to-date care plan detailing the visits they now received. During the inspection the manager updated this person's care plan and risk assessment but this meant this person had been receiving care without an up-to-date copy in the home for staff to follow. Another person had been using the service since March 2017 and only had handwritten notes in their care records rather than a detailed structured care plan. This was confusing and difficult to follow. Another example included a person required two care workers due to mobility, but as their condition had improved they now only required one. However, the care plans had not been updated and there was no information on their mobility needs. This demonstrated an up-to-date assessment of people's needs was not always in place.

A number of people complained to us about the time of calls. Information in people's care files asked them to call the office if care workers did not arrive within 15 minutes of the agreed time. However, there was no information on the agreed call time within people's care and support plans. This meant there was no target time for staff to arrive and people were not clear when to expect staff.

Calls did not consistently take place at the same time each day which meant people's needs were not always met. For example, with regards to pain and continence management. We saw one person's morning call had varied between 6:54am and after 10am. Another person's morning call had varied between 8am and 11am over the course of a few days in June 2017. We also saw an inappropriate gap between calls. For example, on 11 June 2017 one person's morning call was between 10:30am and 11:00am and their lunch call 11:30am to 11:45am. On the 22 June 2017, the person's teatime call was at 16:29pm and then staff returned at 17:52pm for the evening call. This person required four calls a day for pain and continence management and visit times were not conducive to appropriate care in these areas.

We saw teatime calls to another person had varied between 14:57pm and 18:14pm over the course of a few days. A further person required four calls a day for continence care and had a lunchtime call at 11:37am and a teatime call at 18:00pm, a six hours 23 minutes gap instead of the planned four hours. We saw in another person's care records their relative had written as the carers had not been able to arrive on time they had to put their relative to bed.

People often did not receive their agreed amount of care and support. This meant staff were rushed and did not always complete all tasks. The manager and staff told us there was no travel time between calls which meant that staff could not stay with people for their allotted time. We saw one person was due to have a 30 minute call, this was consistently shorter and on one occasion only eight minutes in length. Another person's teatime call had been as short as five minutes instead of 15 minutes. A further person had a 12 minute call in the morning instead of 30 minutes, where care staff recorded they had given a full wash, assisted to dress, provided continence care and transferred the person. Another person regularly had a bedtime call of seven to eight minutes to undress, provide continence care and tidy up instead of 15 minutes. They also had a 10 minute tea call instead of the allocated 30 minutes.

Another person's care records showed they could be low in mood so staff should chat with them. They were contracted to receive four calls a day of 30 minutes in length. Their evening call on 14 May 2017 was only five minutes long, where records stated 'had a chat'. On another occasion, records stated 'had a lovely chat' but the call had only lasted nine minutes.

We concluded the above evidence indicated a breach of Regulation 9 (3) (a) (In person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mixed views from people as to whether their care was formally reviewed. One person said their care plans had been reviewed and they felt involved in this. They said, "We were involved and [name of staff] chatted about things." and "Any concerns [name of staff] comes straightaway. They ring and check we are ok." Another person said, "We have a review every two or three months, they come and ask about everything." Some people said they had not had a review for some time but were satisfied staff knew what to do to meet their needs. One person said, "I had a care plan to start with, can't say I've had a review recently, they ring sometimes."

The service had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Staff we spoke with said they knew how to manage a complaint and felt confident management would listen and act on their concern. One staff member said, "I record all the information in the daily notes and would speak with my line manager." Another staff member said, "I would note it in the book and then ring the office."

Our discussions with people revealed that a number of people were not happy with the service and said complaints had not been appropriately managed. Whilst we saw some complaints had been recorded, this was not consistently the case. For example, we saw a relative had written two negative comments in their relative's daily records about missed calls and medicines concerns. These had been brought back to the office, however, these comments had not been logged as complaints, or incidents and investigated. Other complaints although logged, recorded only a very brief account of the complaint, with a lack of clear information to demonstrate they had been investigated and actions put in place to prevent a re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

These are some of the comments from some of the people who used the service:
"I'm frightened to complain in case I don't get any care at all." "I had a formal complaint about their overcharging upheld, there is no acceptance they don't listen or learn. There is a lack of management skills, the front line staff I can't praise enough, the buck stops at the top."

One person told us, "I was told the call would be at 9.30am it's sometimes 10.00am, one day at the weekend it was 12.45pm. I was annoyed at having to sit in my dressing gown until 12.45pm, I am not that type of person, weekends are worse."

Another person said they rang the office one night to establish if someone was coming to put their wife to bed. We were told the manager from the agency 'screamed' at them down the phone "What are you ringing me for" and continued to use extremely abusive language.

One person said, "What a way to run a company, I can check myself verbally, my fear is not for my wife, I fear for old people who can't speak for themselves and have to live in that company's hands."

In the PIR the provider told us, 'Regular management meetings ensure adequate staffing levels to meet the needs of service users. Internal auditing system to ensure quality provision is ensured.'

Overall staff told us they found the management and office staff to be helpful and supportive. However, several staff told us there was one office worker who needed to improve their approach. They told us if they spoke with them on the phone they were not always helpful and could be "very rude" to care staff. Staff told us they had raised this with the manager and the staff member has been told to improve, but care staff told us this had not happened. In discussion with the registered manager about the concerns raised by staff they told us this was been monitored and is been addressed.

Staff told us they thought that Bronte Care Services provided good quality care and most of the staff we spoke with told us they would recommend the provider to others.

Staff told us rota's were not well organised and they sometimes had to pick up extra calls outside their normal geographic area at short notice. This causes stress and meant people did not receive calls at consistent times. There was no travel time allocated on rotas. This increased the chances people would not receive a timely and consistent service and provided further evidence the service was not well-led.

Staff told us rota's were not well organised and they sometimes had to pick up extra calls outside their normal geographic area at short notice. They told us when extra calls were added to their rotas this often caused them increased stress and meant people did not receive calls at consistent times. There was no travel time allocated on rotas. This increased the chances people would not receive a timely and consistent service and provided further evidence the service was not well-led.

Staff described how they would often not know about changes to their rota until the last minute. For example, one staff member told us, "They change me around every day and give me too many calls which makes me stressed as you can't always get around to everyone on time. They often add extra calls onto your rota, you can check your rota on your phone in the morning and then again at lunchtime and they will have added additional calls without telling or asking you."

There was a lack of review of medicine and daily records to check they were completed appropriately. We found a number of discrepancies in MAR charts which should have been identified through audit and action taken to prevent a re-occurrence. Care files and risk assessments were not subject to audits or checks. We saw some blank audit documents in some people's care files. We found a number of discrepancies with care and support plans and a number of breaches of regulation which should have been identified and rectified through robust quality assurance systems.

We found appropriate records were not always kept and care staff did not always document care calls. We found a number of occasions when care records were not completed. When we checked these with the electronic call monitoring system we found the calls had taken place but records had not been maintained. For example, one person's daily care records appeared to show a missed call on 18 May 2017. The person's relative had written an entry querying whether the call had taken place. During the inspection, the provider looked at electronic records which showed the call took place but had not been recorded. This also showed poor communication with family support of people.

Some people were missing care plans or sections of care plans. In some instances the manager said there would be a complete copy in the home, but not the office. However, this meant there was no master copy of the care plan and should the home version go missing there would be no record the care plan existed. It also made amending and auditing of care plans to be challenging.

We concluded there was a Breach of Regulation 17 (Governance) of the Health and Social Care Act Regulations 2014 as systems in place had not been effective to audit, monitor and ensure continuous improvement in the service.

The manager said satisfaction surveys had not yet been sent out in 2017 to people who used the service to ascertain people's views on the service. They said the surveys had been due out in January 2017 but would ensure this was done in the near future.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People often did not receive their agreed amount of care and support. Staff were rushed and did not always complete all tasks. Care plans did not always provide accurate detailed information about people for staff to be able to provide individualised 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 Medicines were not always managed safely in the service and this placed people at risk of harm. People who used the service had been put at risk of harm from missed calls.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no travel time, staff cannot be deployed in the right places at the right times. We found the audit system was not sufficiently robust.

The enforcement action we took:

Warning notice