Comfort Call Limited

Comfort Call Bristol

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 21, 22 and 23 June 2017 and was announced.

When the service was last inspected on 31 March 2016 we found two breaches of the Health and Social Care Act 2008. Breaches of legal requirements were found where medicines were not always managed safely and up to date, accurate records were not maintained. These breaches were followed up as part of our inspection, however we found the required improvements had not been made.

You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Comfort Call, on our website at www.cqc.org.uk

At the time of this inspection, the service was providing care and support to 133 people in their own homes.

There was not a registered manager in post. A manager was in post who was going through the registration process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us there were not enough staff to meet their needs. Staff often arrived late to provide care and support to people, or missed visits altogether. Staff rotas showed staff were sometimes expected to be in two places at once, and were not always given sufficient travel time between people. People told us they had to rely on family members for their care. Managers had not identified the shortfalls with the rotas and had prioritised other things.

Not all risks to people had been assessed. Risk assessments did not always inform the plans of care. Staff did not have guidance in care plans what to look for if people with health conditions, such as diabetes, were to become unwell. Staff told us they had not received training to support people with complex needs.

People did not always have their medicines in a timely way. The manager had identified some people could not be guaranteed to receive their medicines at specific times, so had informed the local authority, who were in the process of transferring their care to other providers.

Where people had consistency in staffing, staff knew the people they supported and provided a personalised service. Some people did not benefit from consistent staffing and had different staff for many of their visits. People and their relatives had mixed views about the skills and caring nature of staff. We observed some positive interactions between staff and people they supported, however we also observed some staff were rushed.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work with the service. Staff received training in manual handling, safeguarding and infection control. Staff had not received specific training for conditions such as pressure ulcers or epilepsy and told us the training they were given wasn't enough.

Care plans were in place detailing how people wished to be supported and families were involved in making decisions about their care. Although people had been involved in writing their care plans, most people told us they were not involved in regular reviews of their care. People were supported to eat and drink.

People told us their complaints had not always been responded to. The manager explained complaints had not been logged prior to them joining the service. People's feedback was regularly obtained via telephone calls and quality assurance visits.

The staff understood their role in relation current legislation around helping people to make decisions where they lacked capacity. People told us staff respected their choices.

The manager and provider undertook audits to review the quality of the service provided and made some of the necessary improvements to the service.

We found five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during our inspection. 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?

Inadequate

The service was not safe.

People told us there were not enough staff to meet their needs. Staff did not visit to provide care and support to people in line with times arranged. Staff rotas showed staff were sometimes expected to be in two places at once.

Risks to people were not always assessed. Staff did not have guidance to look after people with some health conditions.

People could not always expect to receive their medicines as they had been prescribed.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt they did not have the skills and knowledge to meet people's needs. Staff were not provided with specialist training for supporting people with complex needs such as dementia or epilepsy.

People were supported by staff who were aware of the requirements of the Mental Capacity Act 2005. People told us staff gave them choices.

People were supported to eat and drink according to their plan of care. People nutritional preferences were recorded in care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

People's views were mixed about the caring nature of the staff who supported them. People sometimes received care from staff who had got to know them well.

Staff were respectful of people's privacy. We saw some positive interactions between staff and people using the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place outlining people's care and support needs. However, care plans did not always provide the level of detail needed. Most people told us they were not involved in regular reviews of their care.

Where staff visited people regularly, staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People and their relatives felt the staff and manager were not always approachable. However there were regular opportunities to feedback about the service.

People told us they could not always be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Inadequate

The service was not always well-led.

People's safe, high quality care was not supported because the service was not planning rotas in a way which ensured staff were able to complete the visits required.

Staff could not safely rely on the risk assessments and care plans to give them accurate information about how to support people's care.

The management team had recognised the challenges they faced and were taking a more active role in running the service.

Comfort Call Bristol

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21, 22 and 23 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be available to talk with us. It was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, 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 looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During the inspection we spoke with 11 people, seven relatives, seven staff, one company trainer, the manager, the regional director and the regional manager. We looked at seven staff files, five staff rotas, the registered manager's file, 10 care plans and associated records, complaints, quality assurance, policies and procedures, training records, minutes of meetings and other management records. The provider had a protection plan in place, which identified areas for improvement. The protection plan was used to record when actions had been completed.

Inadequate

Is the service safe?

Our findings

People consistently told us there were not enough staff to meet their needs. People said, "They've let me down quite a bit. They are very short of time. I've got girls coming over from Cardiff because they're short of staff", "I don't think there are enough because they come from Wales and all over the place", "I'm sort of thinking they can't have enough staff because sometimes staff are not turning up or not turning up until it's too late" and, "I don't get the full half an hour I'm supposed to get." Relatives confirmed what people had said. For example, one person who required two staff to provide their care had a relative who told us, "No, because if [name's] regular carer is off then they struggle to get a replacement."

Staff did not always provide the correct number of visits to people or provide the visits at the correct times. People told us, "I complained about people not turning up but they just said they don't have anybody", "You have to keep phoning up to ask where your carer is", and, "Carers have come late or not shown up at all." Comments in one person's care plan stated, "Carers don't arrive when expected" and it was agreed "to ensure carer is not arriving two hours late to calls." Another person said, "Sometimes I only get one carer and this is a double staff call." Other comments included, "Times have been late" and, "One day one week [name] didn't get a call at 9am, [name] got it at 2.30pm."

Staff rotas showed staff were sometimes expected to be in two places at once and sometimes they were not given enough travel time to get from one person to another. For example, the rota for one staff member showed they were expected to start one call five minutes before starting another call, yet both visits were at least 30 minutes long. This member of staff was expected to complete seven calls at different locations, with no travel time factored in. This meant staff were not able to complete the required visits to people.

People told us about the impact the missed and late calls had. People said the late and missed calls meant they became ill with worry, had to rely on family members or simply had no care provided. "I just manage but it has more of an impact on my husband and if it wasn't for my daughter sorting things out before she goes to work it would have even more of an impact", "Well for [name] and myself it's a very serious business because [name] can't do anything for herself and if the carer's not here then she will be left with no care" and "Some days no body turns up. Very awkward, feeling alone because my family all lives away." Staff wrote about the care they had provided in a daily notes book. One person's care plan stated they should receive four visits a day, however their daily notes showed five occasions when they did not have four visits a day. There were occasions when calls were so late, the following visit was cancelled. Another person's care plan stated they should receive three visits daily, however the log of their visits showed they sometimes received four, sometimes three and sometimes two visits daily over a period of nine days. The provider's records showed there had been 18 missed calls in March, April and May 2017. This meant people were not receiving the care and support as identified in their care plans. We fed this back to the managers who told us, "We're fully aware of what we need to do."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in March 2016 we found medicines were not always managed in a safe way. At this inspection, we found the required improvements had not been made. People were at risk of their health deteriorating because they may not receive their medicines on time. The office had a list of names of people who were considered to be time critical, so they could ensure this information was factored in when rotas were drawn up. One person's care plan from the local authority stated their medicines were time critical; however this person's name was not on the list of names for people who needed their visits to be on time. Another person was identified as needing their medicines at specific times; however their morning medicine was given to them between 8am and 8.43am. This meant there was a risk people would not receive their visits in a timely way and so would not have their medicines as prescribed. Another person was supposed to have their medicines at 8am every morning; their daily report showed staff had visited at 8am on one occasion out of 16 visits.

People were not being protected against risks and action had not been taken to prevent the potential of harm. Risks to people had been assessed in respect of falls, nutrition and skin care. However, risks associated with people's conditions had not all been assessed. For example, where people had conditions such as Parkinson's Disease, diabetes, epilepsy, heart conditions or strokes, there was no information for staff to follow if the person showed signs of becoming unwell. Staff we spoke with told us they did not know what symptoms to look out for should the person become unwell and therefore they may not react in the appropriate way to keep the person safe. Staff said, "There should be a specific sheet in the care plans telling us what we should look out for, for everything we come across." One person's care plan stated they used bed rails; however there were no risk assessments in place for this. Where a member of staff had been intimidated by one person with a weapon, no risk assessment had been completed to keep staff safe.

We observed staff prompting people to take their medicines, and saw this had been appropriately recorded in people's records. Where people needed to avoid foods such as grapefruit because it affected their medicines, people knew about this and information was available in their medicine care plans. People's medication risk assessments identified if they were supported by relatives or other carers. However, the risk assessments did not provide guidance for staff on how to support the person if the relative/carer was not able to do so. For example, one person used oxygen from a cylinder; there was no risk assessment in place for this. Two people's care plans did not mention information that had been identified previously by a Local Authority assessment. One person's local authority care plan stated they needed to use pain relief and medicines were given via patches on their skin. Another person's local authority plan stated staff should administer their medicines for them. This meant staff did not have information about the medicines and support these people needed. Two people's care plans and risk assessments gave conflicting information. For example, information in one section of their care records stated staff should prompt them to take their medicines, while another section said staff were to administer the medicines.

Guidance was not always in place for staff to follow to ensure they applied topical creams for people correctly. When people have topical medicines applied, it is good practice for the areas the medicines are to be applied to be identified using a body map. This is so all staff know where to apply it and how much should be applied. Some care plans contained body maps to show staff where to apply the medicines, others did not. People said, "You get changes of staff and someone new every week and then you have to explain everything to them about all the medication [name] is having." One relative said, "They're supposed to help with medication but there are very few of them that are trained to do that, so it's mostly the relative that does it." Nine staff did not have up to date medicine training. Staff did not have their competency to administer medicines assessed.

Staff were aware of the process they should follow for reporting any accidents or incidents. Staff said, "We phone the office as soon as possible" and "We fill a form out in the office." There had been five

accidents/incidents recorded in the past year. However, we found one medicines error which had not been recorded on the computer system. The error had not made the person ill, however the form had not been completed to show any investigation had been carried out, any findings or any corrective or preventative actions taken. The provider's protection plan dated 16 June 2017 stated, "All incidents to be recorded and stored in the incident file" and noted this was with immediate effect. This meant the opportunity to learn from the incident was missed

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

We asked staff to tell us about changes since the previous registered manager left in April 2017. Staff told us previously the rotas had been changed for visiting people several times and the results had been chaotic. Staff said, "There have been lots of changes for the better, but it's not sorted yet", "It's working better now, but we still have a few gaps where the timings are awkward" and, "We need more staff in the field. We're all stressed because we have to cover other staff work." Other comments included, "It's not getting better yet; the mess was so big it will take more than a few weeks."

Environmental risk assessments were in place for peoples' homes to inform staff how to stay safe. For example, if there were any steps to negotiate, the lighting and location of utility points such as stopcocks for turning off water.

Where staff were able to use people's home telephones to log in when they arrived at someone's home, the office were able to monitor if staff were on time or late. This meant they were able to check the reasons why staff were running late and inform people who may be affected. The manager told us, "We're looking at updating the system for staff to use because currently some staff are using timesheets. This means we don't have the information immediately and have to wait for timesheets to be handed in, so information about calls is usually a week late" and "We encourage the staff to let the office know if they're running late, because people are less anxious if they know what's happening."

The service followed safe recruitment practices. The regional director said, "We're bringing new staff in. We've put lots of work into recruitment." The manager told us, "Previously, we didn't have enough staff, now we're starting to do well." Staff said, "Unfortunately they tend to hire a lot of people who leave in a week." The PIR said 117 staff had left in the last 12 months (from March 2016 to March 2017). However, this was similar to the figures expected for a service of this type. The regional director explained the service had been invited to take part in a pilot scheme with the local authority for six months, which would look at ways to improve recruitment and retention.

Staff we spoke with confirmed they had been asked to provide references before starting work. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. The regional manager said the disciplinary process was used where necessary, and gave examples of when they had taken staff through this.

Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of different types of abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

The provider had notified the local authority when they identified they could not get to people who needed calls at specific times. At the time of the inspection, the local authority was in the process of finding new care providers for these people and some people had already been given dates when they would transfer. The regional director said, "I think we've done everything we can to protect people" and "We hold our hands up and say we know we've got issues. We want to protect people and have asked the local authority for support."

Senior managers had made changes to the way the office was staffed. The regional director said, "It's a completely new team in the office." The changes meant more staff were available to manage how the support people needed was organised. The regional director said, "We have seniors in place now and need one more senior member of staff." Each senior will be responsible for doing care plan reviews and updating care plans, and will be completing spot checks on staff.

Requires Improvement

Is the service effective?

Our findings

People and their relatives had mixed views about the skills of staff providing care. People said, "I have no reason to not have confidence in the staff", "They are very, very good indeed. I don't know what I'd do without them" and "They know exactly what they're doing". However other comments included, "They just don't know what they're doing" and "Some of them are alright, some of them you have to keep asking and asking because they don't know what they're doing."

Records showed staff had received some training such as infection control and manual handling but they were not provided with specialist training such as caring for people with diabetes or dementia. Staff told us they felt the week's training they were given wasn't enough because they did not received training for supporting people with complex needs. Staff said, "I've learned more out in the field" and "On the job training is better than the training we've been given." Other comments included, "We try to do our jobs professionally, but some staff can't fill the report books in properly.", "We've not been trained properly, we were given a booklet", "Parkinson's Disease and epilepsy were touched on briefly in induction, but I think proper training should be done" and, "There should be more training about different issues like Parkinson's Disease."

A trainer told us, "Staff do homework for stroke, diabetes and Parkinson's training, then I fill in the gaps." The provider's protection plan dated 16 June 2017 stated, "Staff having a lack of understanding of dementia." The protection plan stated that training was to be arranged. Training records showed nine staff were out of date for manual handling training and 11 staff were out of date for safeguarding training. The manager had a plan to address this and staff were being booked onto training courses they needed.

Where people had pressure ulcers, staff said, "We know to change people's position, apply creams and spot the start of one." However, two people's care plans contained repositioning records that had gaps. Staff told us, and records confirmed they did not receive any training for pressure ulcer care. One member of staff told us they knew how to check mattresses for the correct settings because a district nurse had shown them, another said they didn't know the mattresses should be checked. Staff did not have guidance in people's care plans to follow to inform them if they needed to check mattresses or not.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. Staff said, "The induction trainer was good and went through everything thoroughly" and, "This company does a good induction." New staff were booked onto a one week induction course where training courses such as first aid, manual handling and safeguarding were provided. New staff were then able to shadow an experienced member of staff once their checks and references were completed. Staff who had not worked in care previously were enrolled on The Care Certificate. The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people. New staff completed six months' probation.

People were supported by staff who had supervisions (one to one meetings) with their line manager. The regional manager told us, "It was quite a task bringing staff in for supervision and catching up with missing paperwork." One member of staff told us, "Supervisions weren't happening a while back, but they're taking place now." The provider's protection plan dated 16 June 2017 had identified the lack of support for staff and staff had either received, or been booked for supervision. Staff told us they felt supported by the manager, and other staff. The manager told us a weekly drop in session had been arranged for staff so they could speak with the manager or other office staff without having to wait for a supervision to be booked. Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required.

Some staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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.

We checked whether the service was working within the principles of the MCA. Most people told us they were always asked for their consent before staff assisted them with any tasks. However, two people said, "Some do and some don't" and "No they just get on and do it really, they know what they have to do so they just do it." Staff said, "We've done training around consent", "We make sure we give people choices" and, "We let people decide for themselves." One section in people's care plans contained information for staff about how the person was able to give consent, such as verbally. Care plans also recorded information about relatives who supported people to make decisions.

People's preferences, likes and dislikes and any cultural factors affecting their choices of foods were recorded in nutrition assessments. These assessments also recorded if the person needed any support to eat or drink. Staff had guidance for the position the person needed to sit in to eat, whether they needed any supplements and the portion size the person preferred. Where people were considered to be at risk nutritionally, guidance was provided for staff how to meet the person's needs, such as ensuring the person received fortified drinks. People said, "If I wanted beans on toast or something like that or eggs or anything like that they will do that for me", "They make me a salad every night. I'm quite happy with that." I can always say put a bit more of that on and they do that.
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. For example, one person's care plan showed they had been referred for a mobility assessment after their needs had changed. People said, "Yes staff help. At the beginning of this year I fell and injured myself. Staff stayed with me and called the ambulance" and "They will do if I ask them."

Requires Improvement

Is the service caring?

Our findings

People's views about the caring nature of staff were mixed. People said, "Half of them don't want to do anything", "Half of them don't want to know the job. One of them left all my wet washing on my floor where you can slip." "Some of them are very kind but others just come early and go onto another job". Other comments included, "They are very caring, really good, I'd be lost without them." One person told us how a member of staff helped them when they injured themselves and said, "[Name] stayed to look after a pet and stayed in touch with my friends to tell them what was going on." Other comments included, "They certainly are caring. We have a regular carer and she is very good", "Yes, they were very good" and "Yes they seem very nice."

Observations of the interaction between people and staff were mixed. We saw some positive interactions between staff and people using the service. Most people were relaxed in the presence of staff and appeared to be happy. However, some people with dementia were not able to respond to staff because of their condition. Most staff were attentive and had a kind and caring approach towards people. We also observed some staff appeared rushed. For example, one member of staff told us they were only popping in because they needed to be somewhere else in five minutes time. Some staff we spoke with were passionate in their quest to care for the people they supported. Staff said, "I love my service users", "I'd do anything for them" and "I came back so I could work with them." People said, "The girl I have now is absolutely brilliant and I have her permanently and she is absolutely brilliant. She talks to me and does things for me."

People sometimes received care and support from staff who had got to know them well. People said, "The regular ones know me and they know what they're doing", "The ones that are regular do" and, "Yes I think so." One relative said, "The one that comes consistently do, sometimes people come who haven't been here before." At other times, people did not benefit from consistent staffing. One person said, "Within the last fortnight I've had 12 different girls. Comfort Call just stick anybody in here and it's hard to explain what to do all the time."

People told us they were involved in making decisions about their care and support at the start of the service. People said, "It was discussed with [name]. If there was anything that needed to be changed we were able to say this doesn't work for us", "It was done with her by the lady that came out with the care company, so she was very involved" and, "Another lady came and discussed my needs with me." Staff told us they knew people's individual communication skills, abilities and preferences.

There were a range of ways used to make sure people were able to say how they felt about the service they received. People's views were sought through regular telephone calls from the office and some people had regular visits to complete satisfaction surveys. One person's care plan contained two quality assurance visit records from April and March 2017 which stated, "No changes to care plan." Staff had information about people's cultural and religious beliefs in care plans, as well as details about people's likes, dislikes and preferences.

People told us staff respected their needs and wishes and they felt that their privacy and dignity were

respected. People told us staff treated them with dignity and respect at all times. People said, "Yes they certainly do", One relative said, "Yes the few people that we've met have always treated [name] well." Staff we spoke with said their understanding of showing respect for people's privacy and dignity included making sure people were covered when receiving personal care and they ensured the doors and curtains were closed.

Requires Improvement

Is the service responsive?

Our findings

Most people told us they were not involved in regular reviews of their care. They said, "Apart from that first time, no one else has been since last September", "No not yet. I've been with them for about a year", "I can't remember to be honest; I think I have" and, "They did contact me once but I couldn't meet them. They were welcome to come to me and meet me but nothing ever happened." Relatives said, "The only one would have been when they changed the tea time call from two carers to one but there has been no review since then", "No they haven't", "Yes they did in the beginning. But [name] may have had calls that I've not been aware of." One relative said, "Yes we have. Usually every six months to a year." Staff told us, "We write about any changes we observe in the log books and we phone the office. The seniors should reassess people, but it's not been happening" and "We feed things back to the office, but don't know what they do with the information."

People's needs were assessed before they began to use the service. People or their relatives had been involved in developing their care, support and treatment plans. Plans had been completed for dietary needs, skin integrity, moving and handling and communication needs. There was a malnutrition screening tool assessment. Care contained information about daily routines specific to each person. For example, the support staff should provide at each visit. Speaking with staff they told us, "Care plans tell us about the tasks, some families give us all the information we need."

Where one person required specialist equipment for staff to be able to move them, a specialist trainer had been brought in to train staff. The manager also arranged for the specialist to visit the person in their home, to show them how the equipment worked and to reassure them.

Staff who visited people regularly knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. People said, "They're very kind. If I wanted anything from the shop, my carer will bring it back for me."

Concerns and complaints had not always been used as an opportunity for learning or improvement. People who used the service and their families had been made aware of the complaints procedures. They told us they had made complaints when staff hadn't arrived as expected and said, "I do complain because if no one complains then nothing gets done", "I've rung up and they won't answer" and, "I phoned the regional manager and she was unavailable all the time. They just say they get in touch with her and nothing ever happened" and "I have complained, nothing really responded to. The one who was in charge wouldn't get back to me. I was promised by the receptionist that she would call back but she didn't", "It wasn't responded to at all. Well it's just so frustrating" and "I thought it was a waste of time trying to ring them." Other comments included, "My husband is not one who would think of ringing up to say anything", "You speak to one girl in the office and they don't know what they're doing half the time" and "The regular ones I can't make complaints about." One relative told us they knew how to raise a complaint and said, "Yes. I would start with a phone call to speak to the manager and if it needed to go further I would use the complaints form."

The manager told us complaints had not been properly logged previously. They said this had now been addressed and complaints were being logged. The provider's protection plan dated 16 June 2017 stated, "Concern about responsiveness to complaints." The provider had made safeguarding referrals where there had been frequent complaints made with no improvement in the service. The protection plan stated this had been actioned and would be on-going. There had been six complaints recorded since March 2017. These had been resolved and managed in a timely manner in line with the provider's policy. One person told us, "They were quite sorry and polite and they apologized."

The manager sought people's feedback and took action to address issues raised. People received regular telephone calls to ask if they were satisfied with the service they received, when they were asked, for example, if staff were arriving on time and if there were any problems. People we spoke with confirmed they received regular telephone calls and said, "They call us back every couple of months." The regional director arranged for staff from a different branch to make the telephone calls to people, so people would be able to give honest feedback. Feedback from people from the last audit, completed in May 2017, was that communications had improved. This was because staff were following up on any issues when people had telephoned the office to raise any concerns. People also said that call times had been getting better, until recently when several staff left. People also received regular quality monitoring visits. People had not previously been given the opportunity of completing an annual survey. At the time of the inspection this was due to be sent out. Feedback from people included, "I'm very happy with the carers" and "The service has improved, I'm very happy."

Inadequate

Is the service well-led?

Our findings

At the last inspection in March 2016, we found several shortfalls in record keeping. At this inspection, we found the required improvements had not been made. The provider has failed to fully meet all the regulations. Since the previous inspection in March 2016 there have also been repeated breaches of the same regulations. These include good governance and safe care and treatment.

The provider did not have effective systems in place to monitor the quality of care and support that people received. The PIR said, "Our call monitoring system allows us to monitor planned times of delivery against actual delivery times of care calls. The system helps us to identify and work alongside social workers to see if any packages of care can be increased or decreased." However, managers did not have up to date information from visits to be able to address the issues we found such as missed and late calls. Staff were using different methods of logging their call times which impacted on the ability of the provider to effectively monitor calls. Whilst visiting people in their homes to discuss how they found the quality of care we found staff did not arrive when they were due and did not stay for the length of time they were supposed to. Where care plans showed people needed support by two staff sometimes only one staff arrived which meant care was not able to be provided during those calls.

The provider's planning system had not identified that staff rotas showed staff were sometimes expected to be in two places at the same time, and were not always given sufficient travel time between people. The provider had a protection plan in place dated 16 June 2017 which stated, "All rotas to be examined and compared to carer availability and scheduled visit time." The protection plan also stated, "Staff being put under significant pressure through unrealistic rotas. Staff not staying for allocated times and not completing all tasks." The protection plan stated that these points had been actioned and were on-going. However, these issues were still occurring during our inspection.

People were not being kept safe because the provider's audits had not identified concerns found with medicine management. For example, some people did not have their medicines at the time they were required. The provider had not ensured that staff had their competency to administer medicines checked. Risk assessments and care plans had not been adequately checked to ensure they gave staff the guidance and information they needed to meet people's needs. An audit of care plans had been carried out in March 2017 which identified areas for improvement. However, not all of the actions identified had been completed and the action plans had not been revisited to check this.

Care plans did not always provide up to date information about how to provide the care people needed, what they could do independently and what specific support they needed. For example one person's care plan contained conflicting information. The person was referred to a specialist because their package of care asked for them to be hoisted from their bed into a chair. There was nothing in their mobility care plan to inform staff the person should be hoisted; the person was assisted in bed, however elsewhere in their care plan it was recorded they should mobilise with the use of a hoist. Staff told us they needed more information in care plans.

The provider had not ensured that staff had been trained and were confident in how to support people with complex needs such as dementia. People told us they had not been involved in regular reviews although some quality assurance visits noted there were no changes to care plans or risk assessments needed. Staff said they needed more information in care plans in order for them to fully meet people's needs. Not all accidents and incidents which occurred had been recorded and analysed by the manager or provider.

When the provider had identified shortfalls actions had not always been taken to improve them. For example, the provider's protection plan dated 16 June 2017 stated, "Staff not completing support plans, inexperienced and lack of understanding of how to undertake care plan tasks. Staff not making themselves known when they enter the home." The action needed only identified reiterating to care staff they must introduce themselves at each home when entering the property to reassure the person, and had not identified what actions were needed to address the lack of completing support plans and lack of understanding of how to undertake the tasks expected.

Providers must assess, monitor and improve the quality and safety of the services provided. The provider had not prioritised the care and support people received. As a result of this, the provider had not treated staff rotas as a priority and had prioritised other things.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us it was difficult to speak with the manager and said, "I'm sure that the management could be better", "They're always in meetings", "You can get them on the line but they're always busy" and "On one occasion I spoke with her, she's very nice." Relatives said, "Last time I tried to get in touch they didn't want to know. The only way you will see anyone is if you stand at the door and wait for someone".

Some staff told us morale was quite low. They said, "We work long days so our two hour break is precious, but our time is wasted all the time." They gave examples of when staff had visited the office for supervision, only to be told on arrival that the planned supervision wasn't taking place. The regional director said, "There have been lots of historic issues from the previous manager which we are still dealing with." The manager said, "The senior managers have been really supportive; I couldn't work for a better company."

The PIR said, "The branch is audited twice a year by our internal quality audit team. This audit looks at care planning and reviews the standard of documentation and assessment. Improvement plans are agreed and reviewed where these are required." We saw the most recent quality assurance audits had been used to plan on-going improvements. For example, where audits of staff files had identified required information had not been obtained, staff had been asked to attend meetings where the requirements were explained. Audits had identified 44 files with missing paperwork, mostly records such as health questionnaires, equality and diversity forms. Three staff files did not have full working history; five staff files either had none or one reference and 14 staff had not had supervisions. Staff had been given a deadline when to return any missing information. At the time of the inspection, the manager had obtained most of the required information and meetings were booked to complete the remaining actions needed. The regional director said, "It's a fresh start."

The service had a clear staffing structure; the provider was supported by a regional director and regional manager. The regional manager was responsible for supporting the manager, who in turn managed the care co-ordinators, compliance officer and team leaders. The care co-ordinators managed the care staff. This meant there were clear lines for communication. The management team of manager, regional manager and regional director had become more visible in the service since March 2017 and the changes

they had planned were starting to take effect. However, the regional director recognised the culture of the organisation needed to be changed and said, "It's the hardest thing to do." The regional manager said, "The support I've had is brilliant, I've never worked for a company like it."

The provider's policy stated spot checks should be completed every three months. Until recently, these had not been completed. However, staff had recently been receiving spot checks and these were being used alongside supervision and appraisals to determine the training needs of staff. People's experience of care was monitored through regular telephone calls and visits to people.

The provider was not meeting their stated vision and values, which were to provide flexible, community-based care support of the highest standard that promotes independence, dignity and choice. Staff we spoke with did not know what the vision and values of the service were.

The service is a member of the United Kingdom Home Care Association (UKHCA), whose mission is to promote high quality, sustainable care services so that people can continue to live at home and in their local community.

According to the records we inspected, the service has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.