

Comfort Call Limited

Comfort Call Northampton

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires improvement



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

This unannounced inspection took place on the 8, 10, 15, 16 and 21 December 2015. Comfort Call Northampton provides personal care to people in their own homes, there were 132 people receiving care during this inspection.

Following our inspection in April 2015 the service was rated as 'Requires improvement' due to concerns about the safety and well-being of the people receiving care. We

placed conditions on their registration that prevented the service from taking on any new packages of care, and a condition that they provide all the care that had been agreed with the individual.

The service is required to have a registered manager; 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The previous registered manager left the service in August 2014 and their registration has now been cancelled. Since our last inspection the provider has employed a manager; they had begun the process of submitting an application to be registered with the Commission.

At the time of this inspection we found that although there were areas where improvement had been made, there were still significant concerns in the way that the service operated and in relation to the way in which care was being provided.

People were at risk of serious harm as there were inadequate systems and processes to manage their medicines appropriately. People did not always receive their medicines safely. Where the service had been commissioned to provide people with their medicines, there was no system in place to ensure that staff were aware of all of people's prescribed medicines. Staff had received training in managing medicines; however, the training had not provided staff with the required competency to manage the medicines effectively. This had led to people not always receiving their prescribed medicines, or receiving too much medicine, resulting in potential harm. Although there were systems in place to audit the medicines charts, these audits had failed to identify that people had not received their prescribed medicines.

People were at risk of harm as staff did not report their concerns to the manager. Although staff had received recent training in safeguarding of vulnerable adults, they failed to recognise the significance of what they were finding at people's homes. People relied on staff to notice when they required referral to health professionals or required equipment. Staff did not report any concerns routinely back to the manager, which had left people not receiving their medicines or not being referred to the commissioners or GP for review.

People did not always receive their planned care because staff did not always turn up at the time planned or spend enough time with them to provide the care. Staff had been allocated to more than one person at a time and travel time had not been accounted for when planning

calls. The manager was unaware of the number of calls that were not carried out as planned as there were no effective systems in place to identify this. There was a failure to allocate time to provide people's planned care.

Processes designed to monitor the quality of the service were not always effective. Although systems to monitor the quality of the service had improved, the systems themselves failed to identify significant concerns. Where audits and checks were carried out, they did not identify issues which could affect people's safety and well-being.

People did not always receive adequate food to maintain their well-being. Some people required assistance with preparing their food and drink, staff received training in food hygiene but not in the preparation of food. Some people did not receive regular meals.

People's risks were identified and assessed, at the time of their review by the commissioners. However, not all people's risk assessments had been updated when their care needs changed. Household and environmental risk assessments were completed and the outcomes were taken into account in helping to make the environment as safe as possible.

People's experiences were dependent upon having regular care staff. Where people had regular care staff they spoke highly of them and valued their therapeutic relationship. However, the system for allocating care staff did not always ensure that people received the same care staff at the same time every day. Where people did not receive care from the same staff every day, they expressed their dissatisfaction.

Verbal complaints had not always been responded to and there was no record of these verbal complaints. Where people had made a formal written complaint there was a system in place to deal with these; complaints had been responded to in a timely way and actions had been taken in response to people's concerns. However, lessons learnt from each complaint were not always shared with all staff and they were not applied to all care packages.

People's preferences and choices were not always listened to and there was no provision in the system to allow people to choose when they wanted care.

Summary of findings

People received care from staff that had undergone the appropriate employment checks. New staff underwent an induction period where they received training and shadowed experienced staff during their first calls.

We identified that the provider was in breach of six of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end of this report the action we have asked them to take.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- **Ensure that providers found to be providing inadequate care significantly improve.**
- **Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.**

- **Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.**

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

People's medicines were not managed safely.

People were not safeguarded from harm as staff did not recognise when people were at risk or report their concerns.

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

Risks were not regularly reviewed or updated.

Staff had been appropriately recruited.

Inadequate



Is the service effective?

The service was not effective.

People's care was provided by staff that had not had enough training and supervision to support them to carry out their roles.

People did not always receive adequate food to maintain their well-being.

People relied on staff to refer them for health reviews, but staff did not routinely report any concerns back to the manager.

People had mental capacity assessments in place for their medicines.

Inadequate



Is the service caring?

The service was not always caring.

People were not supported to make choices about their care and the provider did not always respect people's preferences.

People's care and support did not always take into account their individuality and their diverse needs.

People's privacy and dignity were respected.

Requires improvement



Is the service responsive?

The service was not responsive.

People's verbal complaints did not always get reported to the manager by staff, but systems were in place to take action to address people's written complaints or dissatisfaction with the service provided.

People's needs were not always met in line with their individual care plans and assessed needs.

Inadequate



Summary of findings

People's needs were assessed prior to admission but they were not regularly reviewed.

Is the service well-led?

The service was not well-led.

There was a manager in post; however, they were applying to become the registered manager

The provider's quality monitoring systems failed to identify significant concerns.

People were supported by staff that were resistant to change; changes in practice to improve effective communication within the service were in their infancy.

Inadequate



Comfort Call Northampton

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 unannounced inspection was carried out on 8, 10, 15, 16 and 21 December 2015 by three inspectors, one of which was a pharmacy inspector.

We reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us

by law. We contacted the health and social care commissioners that help place and monitor the care of people receiving personal care in their own home that have information about the quality of the service.

We undertook general observations in people's homes, including interactions between staff and people. We observed people's care during their and medicines being dispensed.

During this inspection we spoke with 17 people who used the service and 11 relatives. We looked at the care records of nine people, the medicines charts of 13 and the care rotas for 18 people and 30 staff. We spoke with the registered manager, and six staff including one senior and one support staff. We looked at four records in relation to staff recruitment and training as well as records related to safeguarding, complaints and quality monitoring of the service by the provider and manager.

Is the service safe?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 12 (g) Safe Care and Treatment. This was because people did not always receive their prescribed medicines and the provider did not have systems in place to investigate this.

During this inspection we found that people were at risk of serious harm as people continued not to receive their medicines as prescribed. In particular for seven people, there were 11 different medicines not given and three medicines had been given too often.

Relatives told us of incidents where staff had not realised that a particular medicine was supposed to be given, and that their relative had not received their prescribed medication. We identified that some people had received too much medicine or not had the medicine they were prescribed and that this included a range of medicines such as blood thinning medicines, pain relief and chemotherapy. We contacted the local authority safeguarding adult's team and alerted them to the people's potential risk of harm from not receiving their medicines or receiving too much medicine.

Although senior staff had audited the medicines administration records (MAR), the audits had not always identified the issues raised at this inspection. For example the audits had not identified that medicines had not been given or that some medicines been administered too often. The manager provided themed supervision for the staff who had not adhered to the medicines procedures such as not signing to say they had given medicines. However, the manager had not identified that medicines had not been given, or people had received too much medicine and therefore these issues had not been raised or addressed.

There was no system in place to ensure that people's prescriptions matched the medicines in people's homes and the MAR charts. Staff were not aware of people's prescriptions and relied on labels on tablet boxes and what had been written on the MAR charts previously to inform them of what medicines to give, this had resulted in medicines not being given. For example service user 1 had medicines prescribed that did not appear on their MAR charts, the medicine had not been given for three weeks. They also had medicines (including chemotherapy) that did appear on their MAR chart that had not been given for

more than a week and some medicines had been given more than was prescribed. This person was at great risk as they had been given too much of some of their medicines and not received others. We raised a safeguarding alert.

Where people could have variable doses of medicine, staff were not recording how much they had given, this resulted in health professionals not having the information they required to make an assessments on the effectiveness of the medicine. For example service user 2 had been prescribed morphine, staff did not record how much they had given each time, it was not clear how much morphine the person had been given.

Some people were not getting all of their medicines as staff had not identified or alerted family or commissioners to the fact that there was not enough care visits to provide it. For example service user 3 had medicines that needed to be given three times a day, but they only received two visits a day, the carers had not brought this to the attention of the manager.

Relatives complained that staff did not ensure that people had taken their medicine as they had found medicines on the floor and in their clothing. Another relative had made a complaint about medicines not being administered, although the complaint was dealt with, a safeguarding alert was not raised as the person was at risk of harm due to missed medicines.

We brought all of these issues to the attention of the manager and raised safeguarding alerts. We sign posted the manager to the local NHS community pharmacy team who then provided them with medicines management guidance.

This is a continued breach of Regulation 12(b and g) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

At our inspection in April 2015 we found that the provider was in breach of Regulation 13 (2): Safeguarding service users from abuse and improper treatment. This was because the provider had been made aware of missed calls by families, but had failed to notify the Local Authorities safeguarding team. Staff had not received adequate training in safeguarding of vulnerable adults and did not report their concerns to the local safeguarding team.

During this inspection we found that people were at risk of harm as staff did not report their concerns to the manager.

Is the service safe?

Although staff had received recent training in safeguarding of vulnerable adults, they failed to recognise the significance of what they were finding at people's homes. Relatives told us that they did not have enough continence pads and that staff were aware of this. Staff reported to us that some people were at risk of harm due to the lack of equipment such as a bed or pressure relieving equipment, we discussed this with the manager who was not aware of the issues as staff had not brought this to their attention or raised a safeguarding alert. Relatives told us of their concerns that people were not receiving the care they were supposed to receive, such as personal care. One person was at risk of self-neglect, their relative told us of that staff did not encourage them to have personal care and it was now obvious that they were self-neglecting; staff had not brought this to the manager's attention and they had not raised a safeguarding alert. Although the manager had systems in place to report and investigate safeguarding alerts, the staff did not report their concerns to the manager to enable relevant concerns to be investigated or considered in relation to the care provided to people.

This is a continued breach of Regulation 13(2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

At our inspection in April 2015 we found that the provider was in breach of Regulation 18 (2): Staffing. This was because the provider had not ensured that there was enough staff deployed to meet people's needs and people did not know who was going to provide their care and staff did not know their rotas in advance.

During this inspection we found that staff were not effectively deployed. People did not receive their planned care because staff did not always turn up at the time planned or spend enough time with them to provide the care as detailed within their care plans and agreements. People told us they felt rushed, one person told us that staff "have got so much to do, my lunchtime visit is often as late as 2.45pm", this person's records showed that their lunchtime call was allocated at a different time every day. People told us that staff were often very early or very late, one person told us that they had no choice but to go to bed when the staff arrived, even if it was very early in the evening and not as agreed in their care plan. One person told us "I sometimes have to wait for hours for my care. My skin gets so sore because they don't come, they are supposed to be here by nine, but they don't come until 11

o'clock some days." Records showed that this person's morning call could be allocated as early as 7am or as late as 10.15am. Records also showed that some people were receiving very short visits; for example where people were allocated 30 or 45 minutes of care that they would receive less than 10 minutes of care. One relative told us that the carers had said "we get done as quick as we can then we get to go home." We identified many short visits by looking at the rotas, call log ins and daily notes; we brought this to the attention of the manager who told us they were unaware of this. The manager had not audited the times that staff spent providing care.

People received a rota that told them who would be providing their care and what time they were due to visit for the following week. Staff received their rotas that told them who they were to visit and what time they were due to provide care. Staff were often allocated to two or more people at the same time. For example between 8:30am and 9:30am one member of staff was due to provide 45 minutes of care each for three different people. Most calls on the rota began at the same time as the previous call ended, not allowing for travel time between people. We advised the manager of the issue with the staff rotas, the manager told us that they were not aware of them as their computer system did not alert them to overlapping calls. The manager raised the issue with the provider during our inspection; they provided assistance to update their system immediately.

We brought the matter of people receiving shortened call times, and late or early visits to the attention of the manager, we also brought to their attention that staff had been allocated more than one person to care for within the same time slots, and the lack of travel time. The manager told us that they were not aware of this. The manager had not audited the rotas to identify potential problems which could impact on people's care.

This is a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People's risks were identified and assessed, at the time of their review by the commissioners. However, not all people's risk assessments had been updated when their care needs changed. For example when people required more assistance with their medicines. There were a small number of risk assessments that had not been updated since 2014. The assessments included risks to the person

Is the service safe?

and risks within the home. Records confirmed that risk assessments were undertaken to prevent the risk of accidents and injury to the people who used the service. Household and environmental risk assessments were completed and the outcomes were taken into account in helping to make the environment as safe as possible.

People received care from staff that had undergone the appropriate employment checks. Staff confirmed that checks had been undertaken before they were allowed to

start work. Staff files confirmed that pre-employment checks had been carried out before staff started their induction training. The checks included obtaining of references and checks with the Disclosure and Barring

Service (DBS), their work history and their fitness to undertake the role. The DBS check helps employers make safer recruitment decisions and identifies if staff have any criminal records or are barred from working with vulnerable adults. New staff underwent an induction period where they received training and shadowed experienced staff during their first calls.

Is the service effective?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 12 (c) Safe Care and Treatment. This was because people did not receive their care from staff that had adequate training and supervision.

During this inspection we found that staff had received training and regular supervision, however, not all of the training supported them to carry out their roles. Staff had undergone safeguarding training, but this had not prepared them to recognise when people were at risk, or when to report any concerns they had about people's care. Staff had also received training in managing medicines; however, the training had not provided staff with the required competency to manage the medicines effectively and to ensure that medicines were administered in line with people's prescriptions. Where the manager had identified that staff had not followed their training, they provided one to one supervision. The records of the supervision demonstrated that some staff had repeated their training but there was no evidence of close supervision to check staff competencies and to ensure that the way in which they carried out their duties was safe and in line with expectations.

The manager had monitored the number of staff that had received training; however, the records that they provided during the inspection showed that only 50 of the staff were monitored when there were 66 staff employed. The manager later said the records provided represented a snap shot of what had been delivered.

Senior staff carried out spot checks of staff when they were providing care. These identified any good practice and non-compliance with procedures; which were followed up by supervision. Records showed that most members of staff had undergone at least one spot check in the last six months. However, the spot checks had failed to identify that staff were not following safeguarding or management of medicines procedures. These spot checks also failed to identify or address the fact that staff were not always spending the time agreed with some people in order to provide their care thoroughly or in an unrushed manner.

This is a continued breach of Regulation 12(c) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Although the care package for some people included support to ensure that they had enough to eat and drink we found that some people did not always receive adequate food to maintain their well-being. Some people required assistance with preparing their food and drink, staff received training in food hygiene but not in the preparation of food. Some people and relatives told us that people did not receive regular meals as detailed within their care plans. Some people did not receive regular meals. For example, one person told us "I didn't get any hot meal yesterday", their daily notes recorded that they had not received a hot meal on one day because the member of staff that was sent to provide their care did not know how to cook; this person had a bowl of chocolate cereal and fruit for each of their meals that day. The manager had been alerted by staff and had taken action to ensure that staff that were able to prepare meals were allocated to this person. Another person told us they often had to wait until late afternoon for their lunch. Some relatives expressed their dissatisfaction with staff's ability to make a meal, one person told us "there are a couple of carers that will give vegetable and chips with [name]'s meal, but the rest of them don't think, they just put the microwaved meal in front of them" and "carers ask [name] if they want to eat, and if they say 'no', they don't prepare anything, yet if you put a meal in front of [name] they will eat it". This person had been assessed by the local authority as being at risk of self-neglect as they did not have the motivation to make their own meals. Their care plans clearly stated that staff were to provide them with meals and gave suggestions such as sandwiches, soup and baked potatoes. The daily records showed that staff recorded that they had asked them what they would like to eat but they had said they were not hungry, so no meal had been prepared. The manager had not been alerted to this by staff and had not identified this from the daily notes and a safeguarding alert had not been made.

This is a breach of Regulation 14 (2b) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Some people relied on staff to notice when they required referral to health professionals or when they were unwell. Staff told us of examples where they believed that people required additional care, such as a change in a catheter, they had not reported their concerns routinely back to the manager as when we spoke with the manager, they were unaware. We observed that people required further

Is the service effective?

assistance from medical professionals, but the staff had not informed the manager, for example, one person required barrier cream that was not prescribed and another person required assistance for pressure area care. We saw that some people required medication three or four times a day such as antibiotics and eye drops, but were not getting all of their medication as they only had two visits a day. Staff told us that they were aware of this, however, they had not told the manager about every occasion. This meant the manager had not been in a position to talk to families, commissioners or GP about these changing needs in order to agree how to resolve the issue of people not getting their medicines.

This is a breach of Regulation 12 (2a) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

New staff underwent a period of induction where they received five days of training and attended care visits with more experienced staff to get to know people. Staff had a period of probation in which they had to prove that they were competent in their role.

People had mental capacity assessments in place to identify whether they had the capacity to self-administer medicine; these had been carried out at the time of starting the service, although these had not been updated regularly. Where people did not have capacity or chose not to self-administer this was clearly recorded in the care plan.

There was evidence that staff contacted people's relatives or GP when they were unwell. We saw that the on-call log book contained entries where staff had taken appropriate action where people had been unwell. People told us that care staff sought consent before carrying out personal care; they offered choice where appropriate and explained what they are doing at the time. For example one person told us that staff always checked it was alright to apply their creams.

Is the service caring?

Our findings

People's experiences were dependent upon having regular care staff. Where people had regular care staff they spoke highly of them and valued their therapeutic relationship. Relatives told us it was important that staff knew people well as one person stated "the regular carers know to prompt [name] to wash, any new carers take it at face value that [name] has washed, but [name] needs prompting". Staff told us how happy they were about the changes in the service over the last five months, including their regular rotas, one member of staff told us "I can get to know the clients and be able to provide what they need".

However, the system for allocating care staff did not always ensure that people received their care from staff who knew them and understood their needs. Where people did not receive care from regular, they expressed their dissatisfaction. One person said "I get the same carers at night, but during the day I don't know who I will be getting, I have to tell them what they need to do every time." One relative told us that their mother had "a procession of strangers visiting" as they did not have regular staff. People and their relatives told us that staff were often in a rush and did not make beds, wash up or clean up in the bathroom after providing care.

People told us that their care had to fit around the staff, not around their care needs. For example people's rotas would state they would be receiving care at around 9am, but care workers would arrive at 6.30am in the morning. Other people told us that the time they went to bed did not

correlate with the planned visit on their rota, it depended upon when staff turned up, for example where they staff were due to arrive at 9pm to help them go to bed, staff would often turn up much earlier when they were not ready to go to bed yet. In these cases people told us they felt that they had no choice but to go to bed earlier than they had wanted to and earlier than as agreed in their care plan and that they were not happy that this was their only option.

Care plans included information about people's past lives. We observed that regular staff knew people well and that people receiving care and staff spoke comfortably together about what was important to them, for example people spoke with staff about their families.

People told us that they were treated with dignity and respect. We saw that staff closed the curtains when they provided personal care to help maintain people's dignity. We observed staff spoke with people comfortably and there was a good rapport. One person told us that they had the same member of staff for over 12 months; they told us "she is really lovely, we get on really well". Some relatives told us that they were happy with the staff and described how well they communicated with people: "they are lovely with her", "they are cheerful and helpful, they always ask if there is anything else needs doing".

People told us that staff respected their need to have a secure home and ensured that they locked up after themselves. One person said "they [staff] always make sure I lock my door when they leave". Staff used key safes to access some properties, the information about the key safes were kept secure.

Is the service responsive?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 16 (1): Complaints. This was because the provider did not respond to verbal complaints and appropriate action was not always taken to respond to any failures in care identified in the complaints.

During this inspection we found that verbal complaints had not been responded to. People and their relatives told us that they had made verbal complaints about such issues as the timings of calls, the mess left behind by staff. One relative told us “I have let them know that the visits are not equally spaced in the day, but nothing gets done about it”. Another relative told us “staff are always in a rush, they are sloppy and don’t clear up after themselves, I have let the office know but it doesn’t change”. We looked at the complaints records and found that there was no record of these verbal complaints. Where people had fed back at quality monitoring telephone calls that care had not been provided as planned, such as late calls it was evident that staff had not recognised this negative feedback as a potential complaint as this had not been recorded or responded to. In addition there was no evidence that the rotas had been scrutinised or discussion held with staff to establish why they had received late calls. We looked at the rotas for this person and found that the member of staff allocated to them was regularly allocated to other people at the same time. We brought these complaints to the attention of the manager, who told us they were not aware of them.

Where people had made a formal written complaint there was a system in place to deal with the complaint. We saw that people’s written complaints had been responded to in a timely way and actions had been taken in response to people’s concerns. Lessons learnt from each complaint such as missed medicines were not applied to all care packages, as we saw that the same issues were still occurring after the complaint had been resolved. For example where medicines had not been given due to a lack of a current or accurate prescription the manager had not looked at all the other people providing care to see if this was also an issue affecting their practice.

This is a continued breach of Regulation 16(1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People’s needs were not always met in line with their care plans and assessed needs. Staff did not carry out regular reviews of peoples’ assessments and care plans. We found at least two examples where people’s assessments had not been updated for over a year. The manager told us that they had a programme of reviewing the assessments and demonstrated that they had a short list of people who were left to be assessed. However where people’s care had changed there was no clear communication between staff to update them on any changes in care. For example one person required antibiotics three times a day, but they only had two visits a day, there was no provision for the third dose to be given. People did not always receive care that corresponded to their care plans such as the provision of meals, medicines or pressure area care. Only staff who had a regular rota and provided care for the same people had a good knowledge of people’s needs.

People’s needs were not always taken into account when allocating staff. Relatives had complained that the timings of the visits did not make sense as care was not equally spaced throughout the day. Some people’s morning and lunch visits were so close together that their medicines and meals were given within two hours of each other. Other people had allocated calls so far apart that their personal care needs were not met in a timely way. For example, one person required their personal care at around 4pm, however, their allocated calls were constantly booked for 6pm and their night calls at 8pm.

People’s needs were not always met as staff did not stay long enough at their homes to provide the care. Relatives complained that people were unkempt or their homes were left untidy. There were many examples of people being booked for 30 or 45 minute calls and the care workers regularly visiting for less than ten minutes. This had an impact on people’s ability to have hot meals prepared for them, personal care, showers and social interaction. For example the rotas and daily records showed that in one week in November one person received less than 10 minutes of care on 10 of their 14 possible allocated calls. Their care plan stated that they required personal care, meals and medication; this is considered not be possible in the time spent with the person. We found the records for at least six other people who received less than 10 minute calls where they had been due to receive care in

Is the service responsive?

time slots of 30 or 45 minutes long. Considering their care plans it is not possible to see that staff would be able to deliver all aspects of the care required in an unhurried manner in the time that they spent with the person.

People's preferences and choices were not always listened to. One person preferred female care staff, however, a male care staff had arrived at her home to provide care without them being notified in advance or with their consent, this had led to the person refusing care. One relative told us their mother liked to go to bed between 9.15 and 9.45, their rotas showed that staff had been allocated to that time, however, the member of staff frequently turned up before 8.30pm, when they were not ready to go to bed. People did not always know when they were going to receive care as the rotas provided to them did not reflect the actual times that staff turned up to provide their care. This had an effect on people's meal times, their medication and the times they went to bed at night.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People's care plans were individualised and contained information that was relevant to them including their life histories, interests and activities. Staff were able to tell us about people's interests and their backgrounds and this information enabled them to understand and support people. However, there was no provision in the system to allow people to choose when they wanted care, for example an arrangement was made for an early call on a Sunday to enable one person to go to church, but this had not always been adhered to.

Is the service well-led?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 17 (2a): Good Governance. This was because the provider did not have the processes in place to assess, monitor and improve the quality and safety of the service.

During this inspection we found that the provider had taken action to improve the way in which it monitored the quality and safety of the service. However the action they had taken had not been closely monitored for its effectiveness and we continued to identify a number of areas where improvement had not been made.

There was a manager in post; however, they had not successfully applied to be the registered manager as they had failed to complete the process.

The quality monitoring and auditing systems in place were not robust enough to enable the provider to identify and respond swiftly where quality and safety were compromised. The systems in place failed to effectively assess, monitor and mitigate risks relating to the safe provision of care and had failed to secure compliance with regulatory expectations.

At this inspection we identified that the medicine management systems were not safe and found a number of examples where people did not receive their medicines in line with their prescriptions. Relatives and people using the service had raised complaints and concerns about the way in which their medicines were managed however the provider had failed to ensure that improvements were made. Even where staff had identified issues with the management of medicines the manager had not recognised that the issues related to every person receiving medicines and therefore did not mitigate the risks to all these people.

At our inspection in April 2015 we were concerned about the failure to ensure that people using the service received their care calls at the time and frequency that had been agreed with them. In response we placed conditions on the provider's registration to ensure that this happened as agreed with the individual, however at this inspection we again identified significant concerns about the way in which people received their care calls. Although the provider had taken some action to address these failings they had not monitored the effectiveness of the action

taken. They were unaware that staff were at times allocated to more than one care call at the same time; that rotas did not take account of travel time and that staff deployment was preventing people from having choice and control about the way in which their care was delivered.

The provider failed to implement an effective system to monitor whether people were receiving their planned care. Although data was available we found that the provider had not analysed information in relation to staff deployment patterns and in relation to the length of time staff spent delivering care to people in their own homes. We reviewed the data from the 'call log in' and people's daily notes and found over 40 examples where care was booked for 30 minutes or more yet the data showed that the person had received less than 10 minutes of care. People and their relatives also told us that they were not receiving their planned care and staff were rushed.

Staff were friendly and spoke of an improved culture where they worked more closely with the office based staff and manager to provide the care. However, the provider had failed to ensure that communication systems were open and effective at all levels of the service. At this inspection we found that information was not consistently cascaded to the right person and that staff had not always passed key information to the manager so that this could be addressed. Staff had not always communicated concerns about people using the service or changes in their condition to the manager or to relevant commissioners.

The provider had failed to ensure that there were effective systems in place to monitor staff competence and training. During this inspection we found that staff had received updated training in a number of areas however the associated competency assessments did not address the key areas where previous errors in practice had taken place; the provider had failed to ensure the learning from training was cascaded into improved practice. For example where one person had not received their medicines for many weeks, the provider had not checked that staff understood how this had happened to prevent it happening again. The competency assessments were not updated to reflect the learning from incidents.

The provider had failed to implement and monitor systems related to the safe and secure storage of people's records. We asked the manager to provide the daily notes for November for a list of 20 people. Some of the daily notes were stored in the location office, but most were still in

Is the service well-led?

people's homes. There was no reliable system to transfer the daily notes to the location and there was no expectation that the daily notes would be available for scrutiny on a regular basis.

This is a continued breach of Regulation 17(2a) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity

Personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider was not meeting this regulation because:

The provider was not preventing, investigating or mitigating the risks of not providing medicines as prescribed. Regulation 12(2b)

People were not receiving their medicines as prescribed. Regulation 12(2g)

People did not receive their care from staff that had adequate training and supervision. Regulation 12 (c)

The provider did not have suitable arrangements to respond to people's changing needs. Regulation 12 (2a)

The enforcement action we took:

To be confirmed

Regulated activity

Personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider was not meeting this regulation because:

Staff observed potential risk of harm that they did not report to management or the local authority safeguarding team. Regulation 13(2)

The enforcement action we took:

To be confirmed

Regulated activity

Personal care

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The provider was not meeting this regulation because:

The provider did not meet service users' nutritional needs. Regulation 14 (2b)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:

To be confirmed

Regulated activity

Personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider was not meeting this regulation because:

The provider did not respond to verbal complaints. Appropriate action was not taken to respond to any failures in care identified in the complaints. Regulation 16(1)

The enforcement action we took:

To be confirmed

Regulated activity

Personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider was not meeting this regulation because:

The provider does not have the processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17(2a)

The enforcement action we took:

To be confirmed

Regulated activity

Personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider was not meeting this regulation because:

The provider has not ensured that staff have been appropriately supported and supervised to carry out their roles. Regulation 18(2)

The enforcement action we took:

To be confirmed

Regulated activity

Regulation

This section is primarily information for the provider

Enforcement actions

Personal care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider was not meeting this regulation because:

The provider was not providing the appropriate care and treatment to people. Regulation 9(1)a

The provider was not providing the care and treatment to meet the needs of people. Regulation 9(1)b

The provider was not providing the care and treatment which reflected people's preferences. Regulation 9(1)c

The enforcement action we took:

To be confirmed