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**

Summary of findings

Overall summary

This unannounced inspection took place on the 12, 13 and 14 April 2016. Comfort Call Northampton provides personal care to people in their own homes, there were 112 people receiving care during this inspection.

Following our inspections in April 2015 the service was rated as 'Requires improvement' and we placed conditions on their registration that prevented the service from taking on any new packages of care. Following our inspection in December 2015 the service was rated as 'Inadequate' and placed into special measures due to concerns about the safety and well-being of the people receiving care.

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 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 are undergoing the application process to be registered with the Commission.

At the time of this inspection we found that many of the systems that had been implemented to improve the service were ineffective. 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. There was no system in place to ensure that staff recorded all of the medicine they administered. Staff had received updated 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 medicine too frequently, 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 always report their concerns to the manager. Although staff had received recent training in safeguarding of vulnerable adults, when they reported their concerns to the on-call staff they failed to recognise the significance of what they were being told and issues such as missed calls were not escalated to the manager. There was not a reliable process of ensuring that all concerns reported to the on-call staff were analysed for further action.

People continued to 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. Internal audits and checks 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 or nutritious meals.

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. 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.

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 the these; complaints had been responded to in a timely way and actions had been taken in response to people's concerns.

We identified that the provider was in breach of seven 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'.

During our previous inspection in December 2015 we found the rating for the provider to be inadequate and the service was placed into Special Measures at the time.

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.

As the service was placed into special measures we inspected again to see if sufficient improvements had been made. This inspection showed that there remains a rating of inadequate for four key questions and gives an overall rating of Inadequate. This means we will take action in line with our enforcement

procedures to begin the process of preventing the provider from operating the service.

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 were not protected from the risks of management of their medicines.

People were not always safeguarded from harm as some systems were not in place or poorly designed in order that potential issues were identified.

People did not always receive their planned care as there was no system in place to ensure staff were deployed to provide their care.

People were protected by the safe recruitment of staff.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive adequate or regular food to maintain their health and well-being.

Staff were not always skilled to ensure people had nutritious meals.

People received care from staff that did not always have effective training and supervision that supported them to carry out their roles.

Is the service caring?

Requires Improvement

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.

Is the service responsive?

Inadequate

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, assessed needs or personal preferences.

People's needs were not regularly reviewed.

Is the service well-led?

Inadequate

The service was not well-led.

Action taken as a result of our previous inspection in December 2015 had been ineffective.

The provider does not have the processes in place to assess, monitor and improve the quality and safety of the service.

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

People's feedback did not inform changes or improvements to the service.

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 12, 13 and 14 April 2016 by five 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 looked at how people's medicines were administered and spoke with staff about their knowledge and understanding of managing medicines.

During this inspection we spoke with six people who used the service and eight relatives. We looked at the care records of 23 people, the medicines charts of 21 people and the care rotas for 20 people and 31 staff. We spoke with the nominated individual, the manager, and 16 staff including 14 care staff, one senior staff and an auditor. We looked at two records in relation to staff recruitment as well as all the training records and files related to safeguarding, complaints and quality monitoring of the service by the provider and manager.

Inadequate

Is the service safe?

Our findings

At our previous inspections in April 2015 and December 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. Although the provider sent the Commission an action plan we found during this inspection that the action that had been taken had been ineffective and that medicines management systems remained unsafe.

During this inspection we found that most medicines were now being delivered from pharmacies in blister packs, a system which is designed to help support staff to provide medicines to people at the prescribed time of day. However there was no effective system in place to ensure that people's medicines administration records (MAR) always corresponded with the medicines that they were prescribed. We identified for nine people there had been 14 errors where the handwritten instructions on the MAR charts did not correlate with the medicines in the blister packs. For example where Furosemide (a water tablet) was prescribed one tablet in the morning, the handwritten instructions on the MAR chart stated that staff should give one or two tablets every morning.

There was a risk that this person could be given more than their prescribed dose of medicine. Medicines were being dispensed in blister packs by a pharmacist; however, we saw that on occasions, care staff had returned blister packs as there had been mistakes made by the pharmacy. This increased the risks posed to people by not having a suitable system in place to check that the handwritten instructions on the MAR charts were correct at the beginning of the month to identify any potential errors.

We found that staff did not accurately record what medicines people were receiving or report to the management when people had not had their medicines. There had been a recent incident where one person, who was prescribed medicine to prevent a stroke, did not receive their medicine for two consecutive days. Staff had not reported that the person's morning medicines were still in the blister packs in the evenings. The person had a stroke on the third day. People were at risk of harm from not receiving their prescribed medicine and staff not reporting when people had not had their medicines. They provider had not used the learning from this incident to ensure staff always reported when people had not received their medicine and people remained at high risk from staff not reporting.

Where people could have variable doses of medicine, staff were not recording the dose that they had actually given. This resulted in health professionals not having the information they required to make assessments on the effectiveness of the medicine. For example one person had been prescribed morphine; staff did not record how much they had been given each time. This meant that it was not possible to determine how much morphine the person had been given. This had been an issue identified and brought to the attention of the provider during our inspection in December 2015; it is a concern that this had not been addressed and that this practice was continuing. In addition where people were prescribed creams or eye drops, these were not always included on the MAR charts, or signed to say they had been administered.

Some people were prescribed paracetamol based medicines where the pharmacy instructions clearly stated

that they must not have two doses of paracetamol within four hours. We saw that three people had received their paracetamol within four hours on eight occasions. This had put them at risk of harm. We brought this to the attention of the manager and raised safeguarding alerts with the Local Authority. As this issue had been identified in the last inspection, it is concerning that this practice continued and that the medicine audits carried out had not identified or addressed this serious issue.

The manager told us and records confirmed that 63% of staff had received updated medicines training, including a medicines competency assessment; 32% of staff had undertaken themed supervision, where they had received guidance and placed onto extra training. However this had not ensured that medicines were managed in a safe or consistent way.

The provider had carried out three medicines audits in January, February and March 2016 which had identified multiple issues with medicine management; they identified the risk of management of medicines at the service was at 'high risk'. They had developed an action plan for the manager to follow to address these issues however the actions taken had been ineffective and further audits completed by the provider continued to score themselves as at 'high risk'.

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

At our inspections in April 2015 and December 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 concerns raised by families and staff about missed calls, 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 records showed that 93% of staff had received recent training in safeguarding of vulnerable adults. We found that staff were more knowledgeable and that they reported their concerns to the on-call member of staff or directly to the manager.

However, the inadequacy of the provider's monitoring and oversight of the care and support provided meant that people remained at risk of neglect or omissions in care. The on-call records showed that staff and people using the service had raised concerns about missed or late calls, missed or late medicines, missed meals or required medical attention. There was no evidence that the on-call staff had consistently escalated these concerns or recorded the action that had been taken to address these issues. The manager and provider had failed to identify and address the seriousness of these issues and had not recognised that this had compromised people's safety. They had not consistently made the necessary referrals to the Local Authorities safeguarding team and had not notified the Commission of these matters. As a result of our inspection we raised five safeguarding alerts relating to matters that had not been identified as safeguarding issues by the manager or via the provider's audits of the service.

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 and December 2015 we found that the provider was in breach of Regulation 18 (2): Staffing. This was because the provider had not ensured that staff were effectively deployed. People did not receive their planned care because staff did not always turn up at the time planned or failed to spend enough time with them to provide the care as detailed within their care plans and agreements.

During this inspection people told us that staff were often very early or very late for their care calls, this had resulted in people receiving their medicines too early and they did not have a safe amount of time between taking their medicines. Some people required their medicines at specific times, but the rotas did not allocate staff at the same time of day every day. This resulted in people experiencing worsening Parkinson's symptoms as their medicines had been given at the wrong times.

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. Staff told us they did not get travel time within the rota, so they made up time by shortening people's care calls so that they could get around to see everyone. We identified many short visits by looking at the rotas, call log ins and daily notes. The rotas clearly showed that most staff had back to back calls with no travel time. There had not been any quality monitoring of the rotas to look at the time spent at each visit or to address the extensive pattern of short calls; this was a particular concern given that we had brought this to the attention of the manager and provider at our last inspection.

Most 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. However when people showed us their rotas, we saw that their rotas did not match the staff rotas. People told us that they had regular care staff that had every other weekend off, but that other staff had not been allocated to provide their care and support on these weekends. One relative told us "we don't know who is coming, last weekend no-one came at all for the lunchtime visit, [name] did not get his lunch until after 4 o'clock when I visited."

Relatives told us that people had missed calls as there had been a mix up with care staff. The rotas showed that at times more than one care staff was allocated to one person at a time, when they only required one member of staff. In the two week period of the rotas we looked at, this had led to two staff turning up, or staff assuming that another member of staff was going to visit, and no-one turning up. This confusion had resulted in three people missing meals, medicines and personal care.

People who required two care staff to provide their care could not be sure when their care would be delivered, as the rotas allocated the two staff for completely different times, for example, one staff would be booked for 11:30 to 12:00, and their partner would be allocated 12:15 to 12:45 to provide a two person care visit. Staff told us they ignored the rota and contacted the other staff to coordinate when to meet up to provide the care. This meant that people did not receive their care at the times that they expected.

Inadequate

Is the service effective?

Our findings

During our inspection in December 2015 we found that the provider was in breach of Regulation 14 (2b) Meeting nutritional and hydration needs. This was because we found that people were not supported to receive adequate nutrition to maintain good health.

During this inspection we found that people had not been protected from the risks of not eating regular meals. People told us that inconsistent call times meant that they could not always have their meals when they chose to. One relative told us that "if Mum's usual carer doesn't come then the [stand in] carers are never on time. They are often more than one hour late so Mum gets hungry".

One person's care plan stipulated that staff were to prepare three meals each day with one hot meal cooked every day at lunchtime. However, this person told us that "if the carers can't cook, I have cereal as I don't have a microwave". One member of staff allocated to support this person told us that "I am thinking of cancelling my annual leave because I know when I am off that [name] doesn't always get a hot meal". The on-call records confirmed this, as staff recorded that a member of staff that could not cook was allocated the lunchtime call, and was advised by a senior member of staff to just give cereal. We saw records which confirmed that this person, had at times, had cereal to eat for each of their three meals. This person had been assessed and was deemed at particular risk of developing pressure ulcers, which could have been exacerbated by poor nutrition. At our last inspection we raised specific concerns about the nutritional support offered to this person and it is unacceptable that this practice has not been addressed and that they continued to be exposed to this unacceptable level of risk.

The member of staff who could not cook was also allocated to other people who required meals preparing. This meant that people did not always receive their meals because not all care staff had the skills and knowledge necessary to prepare peoples meals. Only 65% of staff had received training in nutrition and health, where all staff would be expected to prepare food and drink for people.

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

During our inspections in April and December 2015 we found that the provider was in breach of Regulation 12 (2c) Safe Care and Treatment. This was because people received care from staff who had not received adequate training and supervision to provide them with the skills and knowledge required to competently carry out their roles.

During this inspection we found that new staff underwent a pre-employment selection training programme and a period of shadowing more experienced staff before they were expected to work independently. We also saw that a range of training was available and evidence that staff would be paid to attend. However, staff were not aware that they would be paid for training and told us that they were reluctant to attend this training. Staff told us and records confirmed that this impacted on their willingness to participate in expected training and to gain the necessary competencies to fulfil their role.

During this inspection we saw areas of practice that had not improved as staff had not developed the skills and competencies required to fulfil their roles effectively. For example, the continued failure to safely manage medicines and the failure to escalate safeguarding concerns. In addition we saw that some staff who were allocated to fulfil specific care duties did not have the competencies required, for example allocation of staff who could not cook where the care package involved required them to provide a cooked meal.

Although there was a structure in place to provide staff with supervision this was not effective. Senior staff stated that they provided routine and focussed supervision sessions and refresher training to address individual practice issues and that they completed spot checks on care staff to observe them providing care. However we saw that this had little impact on improving day to day practice and aspects of the care and support provided remained below the standards expected. Staff told us and records confirmed that they did not always attend their supervision sessions. Although the provider had information which showed that staff would be paid for supervisions, staff were not aware of this as they told us they did not get paid for supervisions and were expected to do this in their own time.

This is a continued breach of Regulation 12 (2c) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in December 2015 we found that the provider was in breach of Regulation 12 (2a) Safe Care and treatment. This was because concerns about the health of people using the service were not being reported back to the manager so that they could be escalated. This meant that changes to people's health were not being addressed and that people were not always receiving the care and treatment that they required.

During this inspection we found that people were supported to access health care services such as GPs and district nurses if they were not feeling well or if staff felt their health and wellbeing was deteriorating. Staff told us that they contacted the office if they identified someone required medical intervention and that senior staff in the office were quick to arrange medical appointments. There was evidence that staff contacted people's relatives or GP when they were unwell and we saw that referrals had been made to medical professionals and the local authority for people that staff had reported were unwell or at risk of self-neglect.

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.

Staff told us that they sought people's consent before providing support. We saw that where possible, people had signed a consent form to agree to an assessment of their needs being completed, a risk assessment of the person and their home, and sharing information with other professionals. In some of the records we looked at, there was evidence that mental capacity assessments had been completed where a person did not have capacity to make decisions about some aspects of their care. This was in line with the requirements of the MCA. For example where people had been assessed by the provider not to have the capacity to self-administer their medication this was clearly documented within their care plan to show that staff were responsible for administering medication. The provider liaised with the commissioners of people's care to arrange for their medicines to be administered by care staff as part of their contract.

People were actively involved in some aspects of the planning and delivery of their care. People and their relatives provided examples where staff asked for their consent whilst supporting them. Relatives stated that when necessary they had been involved in the planning of people's care. One relative said "[name] can sometimes be aggressive, the carers are very good, carers always tell [name] what they are doing and ask their consent. They always involve her and talk to her".

Requires Improvement

Is the service caring?

Our findings

During our inspection in December 2015, we found that the service was not always caring. People's care and support did not always take into account their individuality and their diverse needs. People were not supported to make choices about their care and the provider did not always respect people's preferences.

During our inspection in April 2016, we found that people's experiences were still affected in a negative way by lack of allocation of regular care staff. Relatives told us that it was important that staff arrived when they were due and that people knew who would be providing their care. The way in which the staffing rotas were planned did not always facilitate this. At weekends the rotas did not always have the name of an allocated carer for each planned visit. People showed us their rotas which said "unallocated carer" and one person described this as "unsettling". A relative told us their mother often did not know who would be visiting every other weekend when her regular carer was not working. Another person told us that a new carer visited them to assist with personal care and did not know the level of support that they required. The staff member had relied upon the person being able to tell them how to support them, however not everyone was able to communicate their needs verbally, which put people at risk of not receiving the care they needed when new care staff were allocated to them.

People were not always visited at the time that they had been allocated on the rota. For example one person was due a visit at 6pm to provide support with personal care and administer medicines. Their relative told us that they had often observed staff undertaking this visit at 8pm, when they were retiring to bed. They described how the unreliability of the times of their visits caused their relative distress and anxiety.

People received care at times that did not always take account their needs, wishes or preferences. One person told us that staff came to help them to bed so early that they would decline their help, and as a result they would sometimes stay up all night in their wheelchair as there were no staff allocated after 9pm to help them to bed. They told us, "I can't be expected to go to bed before nine o'clock, I'm a grown man." Their rota showed that care staff were regularly scheduled to arrive at 8pm, and the daily records showed the care staff actually arrived at 7pm; this did not reflect the person's choice to receive care after 9pm.

People did not always feel listened to; particularly with regards to their preferences for male and female carers. During our visit to one person's home, we observed that a male carer was in their home, the person told us "I don't like men doing my personal care, they know that." We found other examples of male care staff being allocated to people to provide personal care where people had requested only female carers for this type of support. We saw that as the rotas did not always have the name of an allocated carer for each planned visit; people did not have the opportunity to challenge the rota if they had been allocated male care staff. People were left not knowing who would be turning up to provide their care. The on-call log showed that people had complained about being allocated male care staff when this had not been their preference. The on-call staff response had differed each time; from persuasion to accept the male care staff to supplying a female care staff. The rotas did not get amended following complaints as people's preferences for female care staff continued to be ignored.

This is a breach of Regulation 9(3)(a)(b) Person Centred Care of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People told us that staff respected their dignity when supporting them with personal care and provided examples how they used towels to ensure privacy when washing. Relatives told us that staff worked in a way that involved the person and respected their dignity. Staff were clear about their responsibilities in this area and were able to describe practical ways in which they would respect peoples dignity. They told us that they ensured curtains were drawn, doors were closed and staff asked people's permission before undertaking personal care. Staff also understood their role in promoting independence and described how they would encourage people to do as much as they were able themselves.

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 relationships. Where people had regular care staff they were generally happy with the way in which their care was provided and described positive relationships with staff. People told us that their regular care staff were kind and they had a good rapport. One person said "I like the regular girls; I have a laugh with them".

Inadequate

Is the service responsive?

Our findings

At our inspection in December 2015 we found that the provider was in breach of Regulation 9 Person centred care. This was because 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.

During this inspection we found that care plans were available for all people who used the service; however they did not always reflect people's current needs and this left people at risk of receiving inconsistent or inappropriate care. For example one person's care needs had changed as their health was deteriorating but these changes were not updated or reflected in their care plan. Another person's mobility had changed and staff needed to use equipment including a hoist to help the person move, but their care plan had not been updated to reflect these changes. Care staff told us they relied on the care plans and communication between the office and care staff to keep them updated. We saw that care staff received texts from the office to alert them to people's changing needs.

People told us that care staff turned up at a different time to the rota. Where people expressed their preference to get up after 8am, care staff had turned up before 7.30am. One person told us they liked to go to bed at 8pm, their relative helps them to go to bed at that time, but the care staff sometimes arrive after they have gone to bed to provide their medicines and personal care. The family told us how this had a negative effect on their wellbeing as they would be settled for the night and care staff would enter their property when they had gone to bed.

People were not receiving care in line with their preferences. Six people we case tracked had specifically requested female members of care staff to support them. Three of them had a male care staff allocated to them to provide care. Their request for female staff only was clearly recorded in the care plan; the staff that allocated the rotas were aware of people's preferences but they continued to send a male member of staff.

People were not receiving their planned care at the times that had been agreed and visits to people were often shorter than the time they were assessed for. We saw many examples of people receiving care up to two hours earlier than planned and also two hours later than planned. This resulted in people receiving care with two visits close together which often meant breakfast and lunch calls were only two hours apart and a longer gap between lunch and tea time visits. Some people did not have their medicines at regular intervals, or waited for long periods for personal care, putting their skin integrity at risk.

People did not always receive care for the length of time they had been assessed as needing. We saw many examples where care staff visited people for less than half of their allocated time of 30 or 60 minute calls. One relative told us "Sometimes the staff are just in and out, the carers don't insist that [name] has a shower, it is very rare [name] has a shower, I think it's been three weeks without one." Where people required 30 to 60 minute calls their care plans stated that they required personal care, meals and medication; this is considered not be possible in the time spent with the person.

This was a continued breach of Regulation 9(1) Person Centred Care of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014

At our inspections in April 2015 and December 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.

At this inspection we found that verbal complaints had not always been recorded when they had been received and care staff did not know how to respond or report complaints that they received. One person told us that they didn't feel listened to and nothing had changed from the verbal complaints they had made, they told us "I complain nearly every day that my calls are too early, but they don't listen." One relative told us that they were afraid to make a complaint because they felt a previous complaint was not addressed properly.

Care staff did not respond appropriately when they received verbal complaints and did not follow the provider's own complaints procedure. Care staff told us that people often complain about the care and support they received, the timings and length of their visits and the effectiveness of some members of staff. One member of staff told us "I don't know what to do when people tell me they are not happy because they get short calls; they tell me 'it is no good telling the office, they don't listen'. I just let them ramble, I can't help them." Another care staff said "People complain all of the time, I just tell them to ring the office; I don't know if the office responds to them though."

The 'on-call' log was used to record when care staff contacted the on-call member of staff. We saw evidence on this log that staff had reported that people had complained about early, late or missed calls, and some people had complained that they had received a male care staff instead of female. We saw that these complaints had not been responded to in line with the provider's complaints policy. The complaints had not been logged and no action had been taken to rectify them.

People were asked for their feedback by telephone, office staff called people to ask their opinion on the care they received. We saw examples where people had complained about the timings of their calls and their rotas, but there had been no changes made to their rotas to improve the service based on people's feedback.

This was a continued breach of Regulation 16 (1) Complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Where written complaints were received, these were responded to promptly and the manager followed the policy and procedure to manage complaints.

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 they regularly care for.

Inadequate

Is the service well-led?

Our findings

At our inspection in April and December 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 although the provider had submitted an action plan following our last inspection, this had not been effective in securing the improvement required in all areas. We identified a number of areas where regulatory requirements were still not being achieved and where this was exposing people to an unnecessary level of risk. This was despite the provider implementing revised quality monitoring systems and processes. Their own audits demonstrated that they were aware that improvement had not been achieved in a number of areas. The provider continued to judge the overall assessment of the service at "high risk".

The action plans in place to improve the service described what improvements was required, but failed to detail the action that the manager needed to take to improve the service. We saw that where some initial changes had been made to improve aspects of the service i.e. medicines management, they had not been embedded into practice and we saw that the improvements made had not been sustained. It was a serious concern that although we brought specific failings to the provider's attention at our last two inspections that these same areas continued to require significant improvement. These included core aspects of people's care and support needs for example; poor medicines management, ineffective staff deployment, poor attention to people's nutritional needs and failure to provide care in line with people's needs and preferences.

We also found that the staffing infrastructure in place failed to effectively meet people's needs. The provider continued to fail to use the information readily available to them to assess the quality and effectiveness of these systems and processes. Staffing rotas did not demonstrate that staff were deployed in a way that reflected people's needs or care agreements. Although the data was readily available and we were able to identify easily where people were receiving short calls, late or early calls or missed calls; the provider's own audits had not identified or addressed these matters. It was evident that there had been no attention to the rotas since our last inspection where we identified the same issues.

At this inspection we found that information was not consistently cascaded to the right person and that although care staff passed some key information to the on-call staff, information from the on-call log was not always passed to the manager so that people's complaints or safeguarding issues could be addressed. The provider had audited the complaints but had failed to identify that people's complaints were not being logged or responded to.

People told us they had been asked for their opinion about the service by telephone and they had provided feedback. This feedback had been used to inform the management of the effectiveness of their improvement measures. However, the telephone interviews had not prompted changes to the way the rota was managed to meet people's needs and preferences, despite people advising them that staff did not stay

for the full time or were late or early for their calls.

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

There was evidence to show that where reportable incidents such as missed calls had occurred that these had not always been reported to CQC. People and their relatives had called the office to inform them that they had not received their planned visits. The on-call log showed that people would call the office when the staff had not turned up for over two hours, whereupon a staff member would be allocated to them. One relative described how their relative had missed lunch and their medicines as their lunchtime call had not even appeared on the rota. Another relative told us their relative had missed two calls in one weekend, where they had not received their personal care or medicines. Some people could not communicate that they had not had their calls; their missed calls were identified in audits, but they had not been reported to the Commission as a notification of alleged abuse or neglect or reported to the local authorities safeguarding team.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was no registered manager in post; however, the manager had made a registered manager application to the Commission.

During this inspection staff told us that they did not receive payment for all the hours that they considered themselves to be working; this was because they were not paid for travel time in between visits and if they needed to stay with a person longer than the expected call time (due to an emergency or changing needs) that they did not get paid for this time. Staff also told us that they do not get paid for their induction, training, supervision and travel. The provider told us that they were compliant with the National Minimum Wage Regulations and that they had been assessed by HMRC as compliant in this area. We asked that they take into account what staff told us and ensure that they remain complaint with these legal expectations.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not providing the care and treatment to meet the needs of people. Regulation 9(1b) The provider was not providing the care and treatment which reflected people's preferences. Regulation 9(1c)

The enforcement action we took:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not preventing, investigating or mitigating the risks of not providing medicines as prescribed. Regulation 12(2b) People did not receive their care from staff that had adequate training and supervision. Regulation 12 (c) The provider did not ensure the proper and safe management of medicines. Regulation 12(2g)

The enforcement action we took:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not recognise when to report abuse to management or the local authority safeguarding team. Regulation 13(2)

The enforcement action we took:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not meet service users' nutritional needs. Regulation 14 (1)

The enforcement action we took:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints 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:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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:

We imposed urgent conditions on their registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has not ensured that staff are appropriately deployed to meet people's needs. Regulation 18(1) 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:

We imposed urgent conditions on their registration