Compleat Care (UK) Limited

Homecare Helpline

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Homecare Helpline is registered to provide personal care to older people, people living with dementia and people with a physical disability. Most of the people who use the service live independently in their own home although the service also provides support to some people who live in three 'extra care' sheltered housing services in Grantham, Bourne and Sleaford.

We carried out a full inspection of the service on 6 April 2016. At this inspection we found three breaches of legal requirements. This was because there were significant shortfalls in the organisation of staffing resources, the monitoring of service quality and the notification of significant issues. We rated the service as Requires Improvement.

Following this inspection, the registered provider ('the provider') wrote to us to tell us what they would do to address these breaches. On 8 December 2016 we undertook a focused, follow-up inspection to check they had followed their plan and to ascertain that legal requirements were now being met. At this inspection we found the provider had not addressed two of the breaches identified at our previous inspection. We issued a Warning Notice for a continuing failure to organise staffing resources effectively and a Fixed Penalty Notice for a continuing failure to notify us of significant issues. The rating of the service remained as Requires Improvement.

We conducted this second full inspection of the service on 21 and 22 June 2017. The inspection was announced. At the time of our inspection, 273 people were receiving a personal care service and 96 staff were employed.

At this inspection we found the provider had not achieved compliance with our Warning Notice and, as a result, was in continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). This was because the provider had taken insufficient action to improve the organisation of staffing resources and the scheduling of people's care calls.

We also found three further breaches of the HSCA. This was because of shortfalls in organisational governance, a continuing failure to ensure people received safe and consistent support with their medicines and a continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively.

We also found action was required improve the communication between office-based and front line care staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

In some areas the provider was meeting people's needs effectively.

The provider had introduced a new system to ensure CQC was notified of any significant incidents relating to the service and, as a result, legal requirements in this area were now met.

Staff knew people as individuals and supported them to have as much choice and control over their lives. Staff were kind and considerate in their approach and went out of their way to help people. Action had been taken to improve the handling of people's concerns and complaints.

Care plans were well-organised and provided staff with clear guidance on how to meet people's needs and preferences. The provider assessed potential risks to people and staff and put preventive measures in place where these were required. Staff worked alongside local healthcare services when this was required. Staff knew how to recognise and report any concerns to keep people safe from harm.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider'), they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the HSCA and associated Regulations about how the service is run. The registered manager was respected by her team.

CQC is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and to report on what we find. Staff had received training in this area and reflected this in their practice.

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.

Staffing resources and the scheduling of care calls were still not managed safely and effectively.

People's medicines were not managed safely in line with good practice and national guidance

Staff knew how to recognise and report any concerns to keep people safe from harm.

The provider assessed potential risks to people and staff and put preventive measures in place where these were required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had failed to ensure the effective training and supervision of staff.

Staff understood the principles of the Mental Capacity Act 2005 and reflected this in their practice.

Staff assisted people to eat and drink whenever this was required.

Staff worked alongside local healthcare services when this was required.

Is the service caring?

Good

The service was caring.

Staff were kind and considerate in their approach.

Staff encouraged people to have choice and control over their lives.

Staff knew people as individuals and went out of their way to help them where they could.

Is the service responsive?

Good

The service was responsive.

Action had been taken to improve the handling of people's concerns and complaints.

Care plans were well-organised and provided staff with clear guidance on how to meet people's needs and preferences.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to comply with the requirements of the Warning Notice issued following our previous inspection of the service.

The provider had failed to take effective action to address most of the areas for improvement highlighted at previous inspections.

Communication between office staff and care staff was not consistently effective.

The registered manager was respected by her team.

Homecare Helpline

Detailed findings

Background to this inspection

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

The inspection was announced. The provider was given notice of our inspection visit because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Our inspector visited the administration office of the service on 21 June 2017. On 21 and 22 June 2017 our expert by experience telephoned people who used the service to seek their views about how well the service was meeting their needs.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report. We also reviewed other information that we held about the service as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies, including the local authority.

As part of our inspection we spoke with 13 people who used the service, two relatives, the registered manager, the managing director of the registered provider and five members of the care staff team. We looked at a range of documents and written records including three people's care files, staff recruitment files, medicine administration records and information relating to the auditing and monitoring of service quality.

Inadequate

Is the service safe?

Our findings

On our last full inspection of the service in April 2016, we found the provider to be in breach of the Health and Social Care Act 2008 (HSCA) due to a failure to ensure the safe and effective organisation of staffing resources and the scheduling of people's care calls. In December 2016, we conducted a follow up inspection and found that there had been no significant improvement in this area and that the provider remained in breach of the HSCA. Following this inspection we issued the provider with a Warning Notice requiring them to be compliant with the HSCA by 31 March 2017.

However, on our inspection of 21 and 22 June 2017, 10 of the 13 service users we interviewed expressed their continuing dissatisfaction with the provider's approach to call scheduling. In particular, the timeliness of their care calls. For example, one person said, "My call time is 7.30am [but] recently [staff came at] 9am. It meant I was stuck in bed for over 12 hours." One person who received 'double up' calls (when two care workers are scheduled to attend at the same time) told us, "Quite often one carer comes first and … has to wait for the other carer. So this makes everything late." Two people told us that late calls were a particular problem at weekends. One person said, "Call times are not too bad during the week [as] I have the same carer. But on a weekend, I never know who will be coming and if they are going to be late or not." Another person told us, "Weekends are worse. It's hit and miss as to when they come."

Three of the five staff we spoke with as part of our inspection also shared concerns about call scheduling and the timeliness of care calls. For example, one staff member said, "I get phoned all the time to go and cover other people's calls. This morning I was busy showering a lady on my regular round and [the office] phoned me to go back to Grantham to do a lady who should have had a call at 9am. It was 9.45am when they called [and] I got there just after 10am. I apologised [and the person] said, 'It's not you, it's the office. They are terrible. It happens all the time.' I feel sorry for the clients. [They] shouldn't be taking on that many people if [they] haven't got the staff." Another member of staff told us, "Clients don't get the calls at the right time as we all get extra calls shoved in. If we've got extras, the calls are late. Almost every day we get extras to cover sickness as a round goes down. Calls are just slotted in. [We] have got to check our phones between every call. [You] don't know where you are going until you check the phone after every call." Commenting on the pressures on care staff, one person said, "They tell me that they have so many calls to do they can't fit them in at the times they are supposed to."

People, their relatives and staff also told us that some care calls were rushed and did not last as long as they were supposed to. For example, one person told us that she had nearly fallen recently when staff were assisting her to get dressed. Attributing this near miss to staff rushing to complete her call, she said, "I was very scared." One staff member commented, "I feel rushed and stressed every single day. Calls [are] being added in as I do the round. It's awful, it really is. Clients are not getting their allocated time. The clients … deserve so much better. I just feel sorry for them all." Another member of staff said, "You can't give them the care they need as you are constantly rushed. [People] need time." One person's relative told us, "We are allocated 45 minutes but they never stay that long. But they put 45 minutes in the book."

Three of the people we spoke with expressed particular concerns about a lack of staffing continuity from

one care call to the next. For example, one person said, "Very different people come all the time." Another person's relative told us, "They send carers we don't know all the time now." Describing their own experience of being asked to work with people they hadn't met before, a staff member said, "You just get a name and address pop up on your phone. You are walking in blind. [You] don't know what you are going to find."

Three people described the negative impact late care calls had on their health and well-being. For example, one person's relative told us, "When they are late [name] becomes very anxious. She starts to get worked up and this makes her [medical condition] much worse." Another person said, "If I am left too long between my last call and my first call the next day, the skin on my bottom breaks down. This happened the other day." One person who needed assistance from staff to take their medicines told us, "If my morning call is late and my lunchtime [call is] early, which does happen, it means I don't have as much time as I should between me being given my tablets."

When we discussed the issue of call scheduling with the registered manager she told us that a range of initiatives had been put in place to address the need for improvement identified in our previous two inspections. These included changes to the rostering system to enable staff rotas to be prepared a month in advance; a review of care rounds to provide greater staffing continuity and the recruitment of a new 'rapid response team' to provide additional backup cover when required. However, despite these actions, when we analysed the trend of late calls (defined as late by 20 minutes or more), we saw that these remained at a high level. Although there had been a reduction since our last inspection, in May 2017 alone, 2360 calls were 20 minutes late or more. Over 12 months since we had first highlighted this issue, it was concerning to find that people were still experiencing over 2000 late calls every month – an average of over eight late calls per month for every person who used the service.

The continuing concerns expressed by people about late and rushed care calls and the lack of staffing continuity, together with the failure to make significant progress in reducing the high number of late calls, indicated the provider had taken insufficient action to address the requirements of our Warning Notice and improve the organisation of staffing resources and the scheduling of people's care calls. This meant the provider remained in continuing breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last full inspection of the service in April 2016, we also found that improvement was required to ensure people received safe and consistent support with their medicines. At that time, the registered manager told us that further training in medicines was being delivered to every member of staff and a new medicine administration record (MAR) sheet had been introduced.

However, when we reviewed the use of the new MARs, we found inconsistencies in the way they were used by staff which meant they did not always provide a clear and accurate record of the medicines people had taken. For example, the new MAR contained instructions for staff to use a coding system to record any occasions when a person's medicine had not been given or the person had refused it. Additionally, each MAR contained a 'variation sheet' which staff were instructed to use to provide an explanation whenever one of these codes was used. However, when we reviewed one person's MAR, we saw there had been 90 occasions in January 2017 when staff had used the code to indicate that medicines had not been given but had failed to use the variation sheet to provide an explanation. At this inspection, some six months later, there was no evidence that this issue had been followed up by the provider to identify why the person was not receiving some of their medicines on such a frequent basis. On another person's MAR, there were 59 blank entries when staff had neither signed to indicate medicines had been given nor used one of the codes to indicate that they had not. This MAR also dated from January 2017 and, again, there was no evidence that

the provider had followed the issue up to determine whether the person had received their medicines or not. On another person's MAR, staff had used the variation sheet on six occasions in the period 20 – 26 January 2017. Entries included, 'Lunch tablet not taken yesterday.'; 'Lunch and tea tablets left from yesterday.' and 'Took away another few tablets.' Again, there was no evidence that these comments had been followed up to establish the reasons why the person was not taking their medication and what the impact on their health might have been.

When we discussed our concerns in this area with the registered manager she told us that she had introduced an auditing system which team leaders used to review completed MARs and then highlight to her any issues that needed to be followed up. Describing the new system, the registered manager told us, "I look at all the issues the team leaders have picked up. If anything is continuously coming up then [I] put actions in place." In our review of the provider's approach to medicine management we noted one instance when this had been done. However, acknowledging that the system was not yet operating consistently, the registered manager said, "It's supposed to be every month but it's not happening regularly." At the time of our inspection, the registered manager was still completing her review of the audits of the January 2017 MARs. As described above, this meant that potentially significant issues relating to people's medicines from six months earlier had still not been reviewed by the registered manager to identify the need for any follow up action to ensure people's safety and welfare.

The provider's continuing failure to ensure people received safe and consistent support with their medicines was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When someone started using the service, a senior member of staff conducted an assessment of the person's needs and preferences which was used to develop a full individual care plan. As part of this process, a range of possible risks to each person's wellbeing was considered and assessed, for example risks relating to skin care. We saw that each person's care record detailed the action staff were expected to take to address any risks that had been identified. For example, one person's care plan contained very detailed instructions on the use of specialist equipment the person had in their home.

The provider also took account of any risks to staff, many of whom worked on their own. The registered manager told us that staff had telephone access to senior staff whenever this was required. She also told us that an account had been set up with a taxi firm which non-driving staff could use if they had any concerns about their safety, particularly if they were working after dark.

Staff were aware of procedures designed to protect people from abuse. They were clear about to whom they would report any concerns and were confident that any allegations would be investigated fully by the provider. Staff said that, where required, they would escalate concerns to the relevant external organisations, including the local authority safeguarding team and the Care Quality Commission.

The provider had safe recruitment processes in place. We reviewed staff personnel files and saw that the provider had completed the necessary checks to ensure new recruits were suitable to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last full inspection of the service in April 2016, some people told us that not all staff had the necessary skills and knowledge to meet their needs effectively. Following that inspection we told the provider that action was required to address this shortfall.

At this inspection, we found that the provider continued to maintain a record of staff training requirements and organised an annual programme of initial and refresher training courses to meet these needs. Describing the approach to refresher training, the registered manager told us, "[We] do something each month. They get an information pack with multiple choice [questions] to complete and return." Staff we spoke with had mixed views about the effectiveness of this approach to meeting their training needs. Talking positively about training provision in general, one member of staff said, "[It's] all good." However, talking about their recent medicines refresher training, another member of staff said, "I think the [refresher] training could be better … more in depth. When refreshed on paper it's not the same as actually physically receiving training."

New members of staff participated in an induction programme which included a period of shadowing an experienced member of staff before they started working on their own. New starters also completed the national Care Certificate which sets out common induction standards for social care staff. Reflecting positively on their own experience, one recently recruited member of staff told us, "My induction was very satisfactory. I give it the thumbs up." However, despite this feedback, two of the people who used the service expressed their concerns that some new staff lacked the skills to care for them safely, particularly in relation to moving and handling techniques. One person told us, "I get worried when new carers come. They don't always know how to use the hoist properly." Another person's relative said, "My wife was dropped on the floor and the new carers didn't know how to get her up." Over a year since we first highlighted the issue, it was concerning to receive feedback that indicated the provider was still failing to ensure all staff had the skills and knowledge necessary to support people safely and effectively.

At our last full inspection of the service, we also found that supervision of staff was not being delivered consistently in line with the provider's policy. Again, following that inspection, we told the provider action was required to address this shortfall.

At this inspection, when we asked the registered manager about the systems she had put in place to ensure staff received effective supervision in their role she told us, "They have four formal episodes [of supervision] a year. A one-to-one recorded supervision, a recorded appraisal, a spot check and a telephone supervision. Everyone is getting that. No slippage." Records confirmed that the staff who were line-managed by the registered manager were receiving the formal supervision she described, addressing the need for improvement from our last full inspection. However, during our inspection, we were advised that the staff who worked in the three 'extra care' housing services were line-managed, not by the registered manager but by the managing director. When we talked to a staff member who led a team working in one of these services they told us, "I regularly have one-to-one conversations [with the managing director]. [But] they are not documented. I don't get a record. [He] doesn't supervise my practice with staff." Going on to talk about

the team she managed, the same member of staff said, "I wouldn't say I do … regular supervision. [I am] not aware of the company's approach to supervision. No one has brought my attention to the policy." When we shared this feedback with the managing director he confirmed that staff supervision in the extra care schemes was "done on a more informal basis". Over a year since we first identified the need for improvement in this area, it was concerning that the provider was still failing to ensure all staff employed in the service received the formal supervision it specified as necessary to enable them to carry out their role effectively.

Taken together, the provider's continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the provisions of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Commenting on the importance of trying to give people as much control over their own lives as possible, one staff member told us, "I listen to their preferences … and give them choices."

The registered manager told us that she made use of formal 'best interests' decision-making processes whenever this was necessary. For example, discussing one recent case, she described how she had supported staff to make an important decision to protect someone's health, working in close consultation with the person's relative.

Staff assisted people to eat and drink whenever this was required. Staff were aware of each person's particular likes or dislikes and the importance of offering people choice. For example, one member of staff said, "I prepare the meals [which are mainly] microwave meals. [But] it's important to give plenty of choice. If they request a sandwich, I'll make a sandwich." People's care records detailed any risks that been identified in respect of their nutritional requirements and the registered manager told us that food and fluid charts were available in people's care files for staff to use where necessary. Staff were also aware of the need to encourage people to keep well hydrated. Describing their approach in this area, one staff member said, "In hot weather I make sure they have a lot to drink."

Wherever necessary, staff also worked alongside a range of local health and social care services on behalf of the people who used the service, including district nurses, occupational therapists and GPs. Describing the importance of maintaining a proactive approach towards people's health, one staff member said, "We work very closely with the district nurse team. If [we are] concerned in any way [we] call them out."

Good

Is the service caring?

Our findings

Despite some people's frustration with the provider about late and rushed calls which is described elsewhere in this report, almost everyone we spoke with stressed that the individual members of the care staff team were kind and considerate in their approach. For example, one person said, "[Name] is brilliant. Nothing is too much trouble." Another person told us, "I have carers with a capital C. They really do their best for me all the time."

Outlining her personal philosophy of care, the registered manager told us, "We [aim to] promote privacy and dignity at all times. I always say [to staff] to look after [people] as if they were their mum or dad. [And] be respectful … more than anything. They are going [into] their homes." This commitment was understood by staff and reflected in their work. For example, talking of one person they supported, one member of staff told us, "[They] like to be dried in a different way to anyone else I've known but because that's what they like, that's what we do." Commenting positively on the attitude of the staff who supported her, one person told us, "I can't fault the care staff. They do all they can to help me." Another person said, "Without the carers I couldn't manage at all."

Care staff told us of other ways in which they tried to meet people's individual needs and preferences, in ways that sometimes went above and beyond the formal requirements of the homecare contract. For example, talking of a person they supported, one staff member said, "If she wants a cake picking up from Tesco, I do it for her. A little thing for me but a big thing for her." Describing her own willingness to do all she could to help the people she supported, another member of staff said, "If they want anything extra, like putting their clothes in the washing machine, their needs come before mine."

Staff were committed to helping people to maintain their independence. Describing how they encouraged people to do as much as they could for themselves and exercise as much control over their lives as possible, one member of staff said, "Some people can get dressed by themselves. I encourage them. It gives them independence in their home." Confirming the approach of staff in this area, one person's relative said, "I can hear the staff encouraging [name] to do what she can for herself."

Staff also told us of their commitment to supporting people in ways that maintained their privacy and dignity. For example, describing their approach to providing people with personal care, one staff member said, "We put a towel over [the person]'s legs. I close the blind and door for dignity and respect. I don't want anyone seeing what is going on." The provider was also aware of the need to protect the confidentiality of people's personal information. For example, care records were stored securely and computers were password protected.

The registered manager was aware of local lay advocacy services and told us she would not hesitate to help someone obtain the support of an advocate, should this ever be necessary. Lay advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes. The registered manager also told us that she would add details of local services to the information booklet that was given to people when they first started using the service.

Good

Is the service responsive?

Our findings

When a person started using the service for the first time, senior staff completed an initial assessment of the person's needs and preferences which was then developed into a full personal care plan. The personal care plans we reviewed were well-organised and included a 'daily routine' summary at the front of each person's plan. The plans set out the detail of each person's needs and wishes, for example, one person's plan specified, "I prefer to remain independent with washing as much as possible. But would like the carer to assist me with washing areas I find difficult." The plan for another person's morning call stated, "I would like the carer to gently wake me up and assist me onto the commode. I will always have a black coffee."

Staff told us that they found the care plans helpful when providing people with care and support. For example, one member of staff said, "Sometimes the person can't remember what needs to be done. But it is all set out on the care plan." Another staff member commented, "The care plans are very helpful. You read it and it tells you the instructions for that person." Senior staff kept people's care plans under regular review, although the registered manager told us she had recently initiated a catch up as some had "fallen behind". Looking ahead, to further improve the effectiveness and ease of use of the care planning system, the registered manager agreed to review the content of the 'daily routine' summary to ensure it included any significant risks identified in the full care plan.

Staff respected the people they supported and understood the importance of getting to know them individually. One staff member of staff said, "I chat with people and discuss their preferences." Staff used this knowledge to provide support in a responsive way that reflected each person's particular preferences. For example, one staff member commented, "It's just the little things. The tiny details that make the difference."

At our last full inspection of the service in April 2016, some people expressed their dissatisfaction with the provider's response to the concerns or complaints they had raised. Reflecting this feedback, we told the provider improvement was required, particularly in the handling of people's calls to the office.

In response to the findings of our last inspection, the registered manager told us the provider's quality assurance officer had recently been given lead responsibility in this area. Explaining this person's role, the registered manager said, "If [anyone calls with a concern] it's passed to [the quality assurance officer] who gives them a call [or offers] a face to face meeting. A full investigation is opened on everything [and] our plan is to turnaround [it] around within 24 hours." The registered manager also told us that a new call handling system had been introduced within the office to reduce call waiting times. Perhaps reflecting the impact of these initiatives, no one we spoke to on this inspection told us they had experienced difficulty in getting through to the office to raise an issue. Although one person told us that they felt they "never got any joy" if they rang the office to complain, others were more positive and told us that their particular issues had been addressed. Additionally, when we reviewed recent customer feedback questionnaires submitted by people who used the service, we saw that most people had expressed satisfaction with the way any calls to the office had been handled.

Inadequate

Is the service well-led?

Our findings

At our last full inspection of the service in April 2016, we found the provider was failing to ensure the safe and effective organisation of staffing resources and scheduling of people's care calls. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008. In December 2016 we conducted a focused, follow up inspection to check the provider's progress in this area. We found the provider had failed to make any significant improvement and remained in breach of Regulation 18(1). As a result, we issued the provider with a Warning Notice requiring them to be compliant with the regulation by 31 March 2017.

However, as detailed in the Safe section of this report, on our inspection of 21 and 22 June 2017, we found the provider had failed to make significant progress in reducing the high number of late calls and service users and staff continued to express serious concerns about shortfalls in the provider's approach to call scheduling. We found the provider had failed to comply with the requirements of our Warning Notice and, for the third inspection in succession, was in breach of Regulation 18(1).

At our April 2016 inspection we also found shortfalls in the management of people's medicines, staff training and supervision and the handling of people's concerns and complaints. We told the provider that improvement was required. On our inspection of 21 and 22 June 2017, we did find evidence of improvement in the handling of people's concerns. However, as detailed elsewhere in this report, the required improvements in medicines management and staff training and supervision had not been achieved and the provider was now in breach of Regulation 12 and Regulation 18(2) of the Health and Social Care Act 2008.

Taken together, the provider's failure to take effective action to meet the requirements of our Warning Notice and to address two of the three areas for improvement highlighted at the last full inspection, indicated shortfalls in organisational governance which meant people were still not receiving the safe, effective, well-led service they were entitled to expect. This was a breach of Regulation 17 of the Health and Social Care Act 2008.

The registered manager told us that she occasionally delivered care to people, to cover sickness or other staffing shortfalls as required. Talking about the value she placed on having regular contact with the people who used the service and front line staff she told us, "Going out and seeing them is helpful. I do enjoy it." This hands-on, accessible style was appreciated by staff. For example, talking of the registered manager, one member of staff said, "I love her. She's amazing. I feel like I can speak to her [and] she'd listen."

Although, in the light of this feedback, it was clear that the registered manager had the respect of her team, the five care staff we spoke with during our inspection, had very mixed views about the management of the service more generally. Speaking positively, one staff member said, "I think [the company] is well-run. [There is] a really good atmosphere." Another member of staff told us, "They're trying. It's getting better. The new [staff] don't stay long enough to see what the company's really like." However, two of the five care staff we spoke with expressed deep concerns. Commenting on the shortcomings in the provider's approach to call scheduling and the negative impact this had on the lives of the people they supported, one staff member told us, "The office … is incompetent. [This] Saturday [I have] two calls overlapping. I have just spoken to

[staff member in the office]. She said they are all like that this week. We're working on 'system red'. [It's] not the way you'd run a business, it's a shambles. We're letting people down. Failing them miserably. I hate to say it [but] I am ashamed I am part of them." Talking specifically about communication between staff in the office and those providing care, another member of staff said, "Companies I worked for before were a family unit. We looked out for each other. With these there is nothing. I have spoken to the office on several occasions and yet again they have put me on a round [I can't do]. They don't listen to anything you say."

The registered manager told us that one of the office-based care coordinators had left unexpectedly about a month before our inspection. She told us that a replacement had been recruited and would be starting in July 2017. The registered manager told us that, pending the arrival of the new coordinator, "We are all mucking in. [It's] not really causing problems [although we are] counting the days till he joins." However, in the light of the feedback detailed above from two of the five care staff we spoke with, it was clear that further work was needed to improve the communication between office-based and front line staff, particularly in relation to call scheduling.

The registered manager maintained a log of significant incidents that occurred in the service, including any missed calls or local authority safeguarding investigations. She told us that a senior staff member had recently started reviewing each of these incidents to identify any actions that could prevent something similar happening again in the future. The registered manager also described further developments in the use of the provider's 'quality assurance' system. A questionnaire was sent out to people using the service, inviting them to rate their satisfaction with 11 key aspects of service delivery including care planning, contact with the office, care staff attitude and call timeliness. We reviewed a summary of the responses received in the period January to June 2017 and saw this was broadly reflective of the feedback we received from the people we spoke with as part of our inspection. For example, people using the core homecare service had given an average score of 9 out of 10 in response to the question, 'Care staff treat me with dignity and respect'. However, in response to the question, '[Care staff] arrive in a timely manner', people had given an average score of only 6.3 out of 10, the lowest of the 11 average scores recorded. In addition to this overall analysis, the registered manager told us each completed questionnaire was reviewed by a senior member of staff who followed up any scores of five or below, to identify any action required to address the issues of concern. We reviewed some recently completed questionnaires and saw that this process had been followed.

On our previous inspection in December 2016, we found that the provider had failed to notify us of several allegations of abuse involving people using the service which had been considered by the local authority under its adult safeguarding procedures. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009. In response to this breach, the provider told us that they had introduced new tracking and recording systems to ensure the necessary notifications were submitted to CQC in the future.

In preparation for our inspection of 21 and 22 June 2017, we identified that there had been several cases in the previous six months when allegations of abuse concerning people using the service had been considered by the local authority under its adult safeguarding procedures. We were pleased to see that, on each occasion, the provider had notified us of these allegations, as required by the law. We found therefore that the provider had taken sufficient action to address the breach of Regulation 18(2)(e).

During our inspection we saw a copy of the report and rating of our last inspection was on display in the service office and on the provider's website, as required by the law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's continuing failure to ensure people received safe and consistent support with their medicines.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider's continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively.