Burbage Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Burbage Homecare on 19 April 2018. The visit was announced. The provider was given 48 hours' notice of our visit because the location provides a domiciliary care service. We needed to be sure that someone would be in the office. The service provided domiciliary care and support to people living in Leicestershire. At the time of our inspection there were 65 people using the service.

Not everyone using Burbage Homecare received the regulated activity; personal care. CQC only inspects the service being received by people provided with personal care, help with tasks related to personal hygiene and eating. Where they did we also took into account any wider social care provided.

At the last inspection in February 2017, the service was rated 'Requires Improvement'. At this inspection we found the service remained 'Requires Improvement'.

The service had a registered manager. The registered manager was also the provider. 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.

We found concerns with regard to the timings of people's calls. The majority of people we spoke with told us they never knew when support workers would arrive to carry out their care and support and some had experienced missed calls. Concerns were also found with regard to the regularity of support workers, with people not knowing who would be visiting them.

People told us they felt safe with the support workers who visited them on a regular basis but not so much with the support workers who were new to them.

The staff team had received training on the safeguarding of adults and were aware of their responsibilities for keeping people safe from avoidable harm or abuse. The provider/registered manager and the management team were aware of their responsibilities for keeping people safe, though processes had not always been followed.

People had the opportunity to be involved in how the service was run through the use of surveys. However, it was not always evident that people's views had been taken on board or addressed.

Systems in place to monitor the quality and safety of the service being provided were not always effective.

People's care and support needs had been identified and risks presented to either the people using the service or the staff team had been assessed and managed.

Checks had been carried out when new members of staff had been employed to make sure they were suitable and safe to work at the service. Support workers had been suitably inducted and relevant training had been provided to enable them to appropriately support the people using the service.

Support workers had received training in the handling of medicines during their induction and their competency had been checked. People were not always supported with their medicines as prescribed by their GP due to not having regular call times.

A formal complaints process was in place and people knew who to talk to if they had a concern of any kind. People told us whilst they were aware of the process, they did not feel this was always effective.

People were supported to maintain good health. They were supported to access relevant healthcare services such as their GP when needed and they received on-going healthcare support. Nutritional assessments had been carried out and people were supported to have enough to eat and drink.

People told us the support workers were kind and they were treated in a caring and respectful manner. They told us their care and support was provided in a way they wished for and preferred.

Plans of care had been developed with the people using the service and with people who knew them well. We did note not all of the plans checked were up to date however, this was being addressed.

An end of life policy was in place. This showed the staff team how to provide compassionate and dignified care for people as they approached the end of their life.

The staff team were supported through, supervisions, spot checks and appraisals and the majority or those we spoke with felt supported by the provider/registered manager and the management team.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were placed at risk due to not receiving the calls they required. Inconsistency of call times put people at risk of not getting their medicines on time.

People felt safe with their regular support workers but not with support workers they did not know so well.

Risks associated with people's care and support had been assessed though not always in a timely manner.

An effective recruitment process was followed.

Is the service effective?

Good

The service was effective.

People's needs had been assessed before they started using the service.

People on the whole received support from a staff team who had the necessary knowledge and skills.

People's consent to their care and support had been sought and the staff team understood the principles of the Mental Capacity Act 2005.

People were supported with their nutritional needs and assisted to access health care services.

Is the service caring?

Good

The service was caring.

The staff team were caring and people were treated with respect.

People were involved in making decisions about their care and support.

Information about the people using the service was kept

confidential.

Is the service responsive?

Requires Improvement

The service was not responsive.

Whilst there was a formal complaints process in place, people did not find this effective.

People did not receive a service that was responsive to their needs.

People did not always know who would be carrying out their calls or when.

People were involved in the assessment of their needs and the developing of their plan of care.

Is the service well-led?

Requires Improvement

The service was not well led.

Monitoring systems used to check the quality of the service being provided were not effective.

Whilst people were given the opportunity to share their thoughts on how the service was run, action had not been taken to address the concerns people had raised.

People had concerns with how the service was run.

The staff team on the whole felt supported by the provider/registered manager.

Burbage Homecare Limited

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 April 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that the provider would be available to assist us with our inspection.

The inspection was carried out by one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience made telephone calls to people using the service and their relatives on both days of our inspection.

We contacted the health and social care commissioners who monitor the care and support of people receiving care from Burbage Homecare to obtain their views of the care provided. We also contacted Healthwatch Leicestershire, the local consumer champion for people using adult social care services to see if they had any feedback about the service. We used this information to inform our inspection planning.

Before the inspection, the provider completed a Provider Information Return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report. We also reviewed information we held about the service such as notifications, these are events which happened in the service that the provider is required to tell us about.

At the time of our inspection there were 65 people using the service. We spoke with 20 of the people using the service and with 16 relatives. We also visited three of the people using the service in their own homes to gather their views of the service.

During our visit to the office we spoke with the registered provider who was also the registered manager, the

human resource and training manager, the care coordinator, the field supervisor and four support workers. A further four support workers were spoken with over the telephone following our visit to enable us to gather their views of the service.

We reviewed a range of records about people's care and how the service was managed. This included four people's plans of care and associated documents including medicine records and risk assessments. We also looked at four staff files including their recruitment and training records and the quality checking processes that the provider/registered manager completed.

Requires Improvement

Is the service safe?

Our findings

At our last visit in February 2017 we found risks to people's health and well-being had not always been assessed and people's medicine records had not always been completed accurately.

At this visit it was evident the risks associated with people's care and support had been assessed however records we checked had not always been reviewed in a timely manner. The field supervisor explained they were in the process of reviewing people's care records, including risk assessments. This was evident during our visit.

People told us they felt safe with the support workers who visited them, though inconsistency of the support workers was at times a concern to them. One person told us, "I do feel safe in so much as I know that someone is at least coming in to check on me every few hours. My biggest fear is having a fall and not being discovered for several days. At least I know that can't happen while I have my carers." Another explained, "I feel a lot safer when I have carers who I know, and they know me. Unfortunately, that doesn't happen often enough for my liking." A third person said, "I feel safer with the ones who come at the beginning of the week."

A relative explained, "We do feel that [relative] is safe. Alright, we do have our frustrations with the agency, but overall, the carers are in the main, concentrating on helping [relative] to stay well and safe, something that as a family, we're just not equipped to do unfortunately." Another told us, "[Relative] is much happier and less stressed with their regular carers, this in turn means that [relative] is safer as well. Having lots of different carers, and there's been a fair amount of turnover in the staff recently, is disconcerting for them."

We looked at the staffing rota. Whilst there were enough support workers to cover people's care and support calls these had not always been completed. There had been occasions when a person's call had been missed altogether, putting them at risk of harm. For example, staff had failed to turn up for one person's lunch time call. This meant they went without their lunchtime meal and drink and had not been supported with their personal care as recorded in their plan of care. One of the people using the service told us, "I have had a few missed calls, the evening time mostly. I just had to struggle to get myself ready for bed."

Where people needed support to take their medicines, information had been included in their plan of care. We did note not everyone had been supported with their medicines at regular times of the day as prescribed by their GP. This was due to the inconsistency of some people's visits. One person told us, "I find it easier to take my own tablets because I make sure I have them at the same time every day." A relative told us, "I sort my husband's tablets out for him as I'm more reliable than the carers to be bluntly honest."

One of the people using the service lived with diabetes. They required their medicines at regular times during the day so their call times were time critical. On the day of our visit we identified their lunch time call which should have occurred at 12.30pm did not occur until 1.22pm. This meant they did not get their medicines at the time they should. We shared this with the provider/registered manager. They immediately placed an alert on the rota system. They told us this would make sure the person's calls would be carried

out at the agreed times in future.

The provider failed to ensure that their were sufficient staff deployed to meet peoples assessed needs. These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Whilst the management team were aware of their responsibilities for keeping people safe from abuse and avoidable harm, appropriate processes had not always been followed including the complaints process when a missed call had been reported.

The staff team had completed training on the safeguarding of adults and knew what to look out for and what to do if they were concerned about someone's welfare. One staff member told us, "I would report anything to my supervisor or the manager, I feel they would act."

Risk assessments had been completed either prior to, or on the day people's care and support packages commenced. This enabled the management team to identify any risks presented to either the person using the service or the staff team during the delivery of the person's care. Risk assessments had been completed on people's home environment where their care and support was to be provided. This was to make sure it was safe. Personal risk assessments such as falls assessments and nutritional assessments had also been completed. This meant the risks related to people's care and support were, wherever possible, minimised and managed.

The staff team had received training in the safe handling of medicines and were aware of their responsibilities. One support worker told us, "We can prompt medicines but they have to be in a dossett box (a container prepared by a pharmacist)." Appropriate documentation had been completed when people had been supported with their medicines. One person explained, "It all gets recorded in the records, but the times change, depending on when they (support workers) get here." Another told us, "They cream my legs every day. They always wear gloves and sign the book when they have done."

We checked the recruitment files for four members of the staff team and found appropriate recruitment processes had been followed. Previous employment had been explored, references had been collected and a check with the Disclosure and Barring Service (DBS) had been carried out. A DBS check provided information as to whether someone was suitable to work at this service. The people using the service were protected by the pre-employment checks that were in place. During interview, standard interview questions were asked to ensure all prospective staff members were treated fairly and equally.

People were protected from risks to their health and well-being by the prevention and control of infection. The staff team had received training on infection control and personal protective equipment such as plastic gloves and aprons were readily available.

Support workers were encouraged to report incidents and accidents. However, it was not evident that when things went wrong, including the issues around missed and continual inconsistency of calls, lessons were learned or improvements made to the service.

Good

Is the service effective?

Our findings

People's individual and diverse needs had been assessed prior to their care package commencing. The provider/registered manager explained an assessment of need was always completed to make sure the person's needs could be met by the staff team. One of the people using the service explained, "I think my daughter and I met the manager originally. The care plan in my folder has the information in that we gave them. I'm sure that we have met with them since, but I can't remember when." A relative told us, "We definitely met someone from the agency who sat with us and asked lots of questions about my [relative's] needs. I'm sure that their care plan was written up shortly after this meeting. Since then, we have occasionally met with someone from the office to make sure changes in their health have been noted in the plan."

People on the whole received care from a staff team that had the skills and knowledge to meet their individual needs. Staff members explained they had received an induction when they had first started working at the service. Four support workers were attending their induction on the day of our visit. One explained, "It is a three day induction, there are videos and handouts and loads of discussion time. I found it really good, very thorough. It was good for me as I've never done this work before." Another told us, "[Human resource and training manager] is really good, you can ask any questions, she is very knowledgeable." One of the people using the service told us, "I would say they are well trained although I think some are more competent than others. Some could do with more support perhaps." Another explained, "All the carers that come understand my needs. They can see how I am at a particular time, for example they will have my angina spray ready to hand if I have over exerted. They all use the hoist safely and make sure they check my comfort levels." A relative explained, "Some of them are very, very good, some have been there longer, and you can see the difference. Last week we had a new one [staff member] and the quality of care just wasn't there at all. They didn't know [relative] and didn't refer to the care plan."

Support workers had been provided with the opportunity to shadow an experienced member of staff when they joined the staff team. This enabled them to learn the role of the support worker and what would be expected of them. One explained, "I asked for shadowing for the morning and that's what I got which was really helpful. I feel confident and don't feel I have been chucked in at the deep end."

Relevant training and regular updates had been provided to the staff team. This included training in the safeguarding of adults, moving and handling, health and safety and equality and diversity. This meant the staff team could support the people using the service safely and effectively.

The staff team received support through regular spot checks, supervisions, and an annual appraisal of their performance had been carried out.

People on the whole told us the support workers supported them to have sufficient food and drink when they carried out a mealtime call. A nutritional assessment had been completed and the staff team understood the importance of making sure people were provided with the food and drink they needed to keep them well. One person told us, "They'll bring me a sandwich through and make sure I have a hot drink

while they're with me." Another explained, "The carers heat me up a ready meal each lunchtime. They let me know what choices I have and when it's cooked, I have it on my lap as that's easy for me to manage."

People's care and support were provided in line with relevant legislation and guidance. The Mental Capacity Act (MCA) 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. No applications had been made to the Court of Protection. The management team understood their responsibility around the MCA. They explained that if a person lacked the ability to make a decision about their care and support, a best interest decision would be made with someone who knew them well and when necessary, with the relevant professional's involvement. Training in MCA had been provided and the support workers we spoke with understood its principles. One explained, "It's about whether people have the ability to make decisions for themselves. I always communicate with them and discuss things and let them decide."

Support workers explained that they always sought people's consent before providing any care or support. The people we spoke with agreed with what they told us. A support worker told us, "I always make sure they [people using the service] know what I am doing and I ask them if it's alright for me to help them."

Any change in people's health was recognised quickly by the staff team and prompt and appropriate referrals were made to healthcare professionals. For example one support worker on arrival at a person's home, found them unwell. They contacted the providers out of hours contact for advice, contacted 111 and contacted their family. A GP visited and prescribed a course of antibiotics for an infection. This showed us people's health and welfare were taken seriously.

Good

Is the service caring?

Our findings

People told us the staff team were kind and caring and treated them with respect. One person explained, "The ones we have at the moment are respectful and know how to look after us. We don't have any coming at the moment that we don't get on with. They don't rush us, and we have two care plans although I am not sure why." Another told us, "They let me do as much as I can for myself, just help me with the bits I can't do. They do look after my modesty and keep me warm when I'm being washed." A third said, "They are nice and treat me well, very caring, will do anything I ask. I've not got anything to grumble about."

A relative told us, "They are all very patient with [relative] we have no complaints about the carers they have all been super. We couldn't do without them. We look forward to seeing them, very happy with the ones we have. They have set up a lovely rapport with [relative] very similar sense of humour. They fill in the care plan after each visit. I have looked at it from time to time and it seems a true record of what care is given." Another explained, "The carers are wonderful, they really do care. [Relative] never has any concerns about the staff. They are all very professional."

People told us the staff team maintained their privacy and dignity when supporting them. One person explained, "The carers always make sure that the curtains stay shut until I'm fully dressed in the morning." A relative told us, "Mum's regular carers are very good at making sure she always starts the day, at least, in clean clothing. Her appearance was always very important to her."

The staff team told us they had the time they needed to provide the support people required and they gave examples of how they preserved people's dignity when supporting them. One explained, "I always make sure the blinds are closed and when I washing their top half, I always make sure the bottom half is covered."

The staff team had the information they needed to provide individualised care and support. People's preferred routines, the people who were important to them, their likes and dislikes and personal preferences were included in the documentation kept in people's homes. This included the name people preferred to be called. One person told us, "To be honest, I think most of the carers do their best in the circumstances. They sometimes look exhausted when they get to me, but they do try to make sure I'm happy and that things get done how I like them."

People told us that whilst their regular support workers knew their needs and preferences others did not. One person explained, "If I only saw my regular carers, I'd be very happy, but I don't and when carers don't know me, it can be really difficult to try to explain how I like things to be done." Another person told us, "During the evening, it is usually all sorts of different carers who come to help me prepare for bed. I've never had any regular carers really in the evenings. They always seem to have new staff working the evenings." We discussed this with the provider/registered manager. They explained recruitment of staff had been difficult recently but they had recruited further support workers and hoped to improve the consistency of support workers in the future.

The provider/registered manager had received written compliments from people's relatives with regard to

the care and support they had received. One read, 'Thank you everyone at Burbage Homecare for the kindness, support, help and care given to mum over the last few years. You have all been wonderful.' Another read, 'Thank you for the wonderful care you gave [relative].'

A confidentiality policy was in place and the staff team understood their responsibilities for keeping people's personal information confidential. Computers which stored personal information were password protected and people's care records were kept secure. People's personal information was safely stored and held in line with the provider's confidentiality policy.

Requires Improvement

Is the service responsive?

Our findings

At our last visit in February 2017 we found people did not always receive care from regular support workers and sometimes experienced care and support that was not at the agreed times.

At this visit people told us they continued to experience issues with regard to support workers not arriving at the times agreed between themselves and the management team. One person told us, "They have been moving them about. I have one at the moment, but she is not as good as [support worker]. You never know what sort of time they are supposed to come. I have sat here waiting and rung the office to tell them and then found out my carer is sick. In the last six weeks I have been let down on one occasion. They rush around and at times I feel rushed." Another person explained, "It can sometimes be an hour later than when I think I'm expecting them, but I never get a call. They seem to make up their times as they go along."

Relatives shared their concerns with regard to the times the support workers turned up to support their relative. One told us, "Missed calls have declined since [field supervisor] came back. [Relative] only has a carer once a fortnight, but they still can't regularly fulfil the visit and [relative] gets let down still more often than not." Another explained, "The call times are not regular, so you don't know when they are coming. There have been occasions when [relative] has been the last morning call and then the first lunch time call so it can be as little as one and a half hours between meals."
People told us they continued to have concerns with the numbers of support workers who visited them. One person told us, "It is not normally the same carers. It is a very mixed bag and some I get on better with than others."

The provider/registered manager had a complaints process and people were aware of what to do if they had a concern of any kind. People told us that whilst they were aware of the process, they did not feel this was always effective. One person told us, "We've complained about the timings of the calls in the past. Things usually improve for a few days and then they get worse again. It just puts you off complaining in the future, because it's just a waste of time."

A member of the management team had received a complaint regarding a person experiencing a missed call. This had not been passed on to the provider/registered manager for further investigation. We noted on the day of our visit, that whilst the information had now been passed on for investigation, this had still not commenced. The provider/registered manager assured us this would be completed without delay.

Relatives had concerns with regards to the number of support workers visiting. One told us, "I've complained about the timings of [relative's] visits together with the lack of regular carers. Things improve for a bit, but then it all reverts back to how it was." Another explained, "We don't normally get the same carers although it has improved a little since I brought it up with them. At one point we were getting 21 different carers from the 28 visits, but it is about 12 to 14 now."

A relative explained, "There is a definite distinction between the carers and the administration. The carers can get their schedule very late which has resulted a couple of times in non-attendance. If they don't turn up

it means [relative] will just stay in bed. For example, the week before last the regular carer was on holiday and my [sibling] found them in bed as the breakfast carer hadn't turned up. [Sibling] rang the office and they said they didn't have [relative] down for a morning call. Which of course was ridiculous as they have a call every day." Another explained, "It has got worse recently. There have been missed calls and [carer of their relative] can't manage. The company just don't seem to understand the difficulties they leave us with when they don't turn up. I have spoken to them about it and you don't even get an apology. A couple of weeks ago they were very late, and I had to ring only to find out they had cancelled the call due to lack of staff but just not bothered to let [carer of their relative] know. It's a shambles."

The provider failed to take account of peoples complaints to make improvements. These matters constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

People told us they had been visited prior to their care package commencing to determine what help and support they needed. They also told us they had been involved in developing their plan of care. The provider/registered manager explained people's care and support needs were assessed prior to their care and support package commencing. This was so they could assure themselves that people's needs could be met by the staff team. Records we checked confirmed this. From the original assessment, a plan of care had been developed.

The plans of care included people's care and support needs and how they wanted those needs to be met. They included people's personal preferences with regard to how they wanted to be supported and what they preferred to be called. For example, one person's plan of care showed their preferences at breakfast time, it read, 'Prepare my breakfast, normally a cereal bar, or fruit with a cup of white tea.' People's plans of care also included information regarding specific health conditions people lived with. This gave the support workers the information they needed to better support people with their healthcare needs. We did note whilst plans of care were in place, not all had been reviewed in a timely manner. The field supervisor was in the process of updating these to make sure they had relevant and current information included within them.

The staff team had received training on end of life and palliative care and a policy was in place. A staff member told us, "We sit with them [people using the service] and support family members."

The provider/registered manager looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given .The provider understood their responsibility to comply with the AIS and was able to access information regarding the service in different formats to meet people's diverse needs. Staff knew people well and knew how each person communicated.

Requires Improvement

Is the service well-led?

Our findings

At our last visit in February 2017 we found one breach of the Regulations. Regulation 20A, Requirement as to display of performance assessments. People told us communication required improvement. There were continuing concerns from people about the punctuality and the regularity of support workers and the provider's checks on the quality of the service were not always effective in identifying and rectifying shortfalls within the service.

At this visit we found the rating given following our inspection in February 2017 was being displayed at the service. The provider/registered manager is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.

People using the service and their relatives told us they felt the service was not always organised or well led. One of the people using the service told us, "My daughter has a problem with the office. The other Sunday there was a phone call to say they were going to be late on Monday morning as there were staffing issues and would this be a problem? Then the usual carer came at 8.10 but had had to ring the office for her rota and they thought she was still on leave."

A relative explained, "We haven't had any missed calls in the last 6 months or so and when they do come they stay the full length of time, but you are never really sure what time they will arrive. I have brought it up several times, but it has got to a state now that I don't bother as I seem to be wasting my time."

People were not always aware of who the provider/registered manager was. One person told us, "I don't know what is happening in the office. There was a manager last year, but I am not sure the owner would change the way things were done so they left. It seems very disorganised. Earlier this year we had new folders and it took me all afternoon to check them. Some of the numbers were wrong it all seems very inefficient." A relative explained, "I don't know who the manager is, I am not sure they have one at present they do seem to go through them. I think the owner is [name] but I've never met her. I don't think it is at all organised. The carers want to do regular calls and from my perspective it would be much better for my relative to have some consistency."

The provider/registered manager's processes for monitoring the quality and safety of the service had not identified or addressed the ongoing concerns with regard to the punctuality and regularity of support workers. These concerns had also been identified at our inspection carried out in February 2015. People told us the punctuality and consistency of support workers had not improved since our last visit in February 2017.

The electronic rota system showed support workers had not always logged into or out of people's calls and some support workers were logging in remotely (using their own phone to log in and out of a call once it had been completed). This included one support worker logging themselves on as supporting two different people at the same time. This meant the provider could not demonstrate people were getting the calls they had agreed to or required. The provider/registered manager told us they were working with the staff team

to address the use of remote logging where ever possible.

People were concerned they did not know who would be visiting to carry out their care and support. We asked a member of the management team whether people were provided with a rota informing them of who would be visiting. We were told that one or two people did but the majority of the people using the service did not. One of the people using the service told us, "I would like to have a rota so I know who was coming and importantly, at what time. It would make my life a lot easier." We were told this was something the provider/registered manager was looking to introduce.

Whilst people had plans of care and risk assessments in place, not all of these had been reviewed in a timely manner. For example one person's plan of care had not been reviewed since its development in 2016.

People felt communication between themselves and members of the office staff and management team still needed improving. One person told us, "Communication can be quite non-existent most of the time." Another explained, "If I'm not chasing them for information, or to change things, I hear nothing from them. It's definitely a one way street!" A relative explained, "I am not sure how organised the office is. I have in the past requested a carer not be sent and then they have sent them saying they had no other staff available."

Concerns and complaints had not always been handled appropriately or in line with the provider's complaints policy. This included the handling of a complaint following a missed call. This had not been appropriately passed onto or investigated by the provider/registered manager.

People had the opportunity to feedback on the quality of the service. Annual surveys had been used and people told us they were able to share their views on the support they were provided with. One person told us, "We've had a survey to fill in asking how we feel about the service.'' Another explained, "We get a questionnaire from time to time and I always bring up the lack of organisation, but nothing changes." A third person shared, "I always feedback my thoughts on the questionnaires they send but nothing changes." We looked at the surveys returned from the most recent batch of surveys sent out in January 2018. Of the 23 returned, eight included comments. Of those comments seven were negative comments regarding the timings of calls and the inconsistency of support workers. Whilst people's thoughts of the service had been sought, no action had been taken to address the concerns raised.

Staff meetings had taken place. The majority of the staff members spoken with felt supported by the provider/registered manager and the management team. Though some felt concerns raised, including missed and late calls, were not always taken as seriously as they should.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

There was a registered manager in place. 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 provider/registered manager had developed a newsletter for the people using the service and their relatives. This had been made available to everyone involved with the service. The most recent newsletter was seen and included information regarding the current work being undertaken by the field supervisor in updating people's documentation and the ongoing recruitment of staff.

The provider/registered manager was aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always taken seriously or acted upon.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems used to monitor the service were not effective.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The staff team were not suitably deployed to meet the needs of the people using the service.