Comfort Call Limited

Comfort Call (Salford)

Inspection report

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Date of inspection visit:
11 April 2016

Date of publication:
28 June 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced focused inspection of this service on 16 December 2015. During that inspection we found the service failed to meet the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment. The service had failed to protect people against the risks associated with the safe management of medication. After that inspection, the provider wrote to us to tell us what action they had taken to meet their legal requirements in relation to the safe administration of medication.

Comfort Call (Salford) provides domiciliary care services to people living in their own home and manages four extra care housing schemes based in Salford. The service is registered to provide personal care. Care is provided for older adults, which some have deteriorating mental health. The office is situated in Barton Hall Business Centre, Eccles, which has adequate parking available.

There was no registered manager in place at the time of our inspection, though a new manager had recently been appointed. 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.

As part of this focused inspection we checked to see that improvements had been implemented by the service in order to meet legal requirements. Prior to this inspection we received a number of significant concerns as a result of safeguarding referrals made to the local authority and complaints made by people who used the service and their relatives regarding the service they received. This related to a high volume of missed and late calls, which impacted on the services ability to administer medication safely. This report only covers our findings in relation to these requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Comfort Call (Salford) on our website at www.cqc.org.uk.

During our inspection, we identified three breaches of Regulations of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 (Part 3), in relation to the safe management of medication, staffing and good governance. You can see what action we told the provider to take at in order to address these concerns.

At the last inspection, in December 2015, we found that medicines were not handled safely and we told the provider they must take action to improve the safe handling of medicines. We visited the service on 11 and 13 April 2016 to ensure that improvements had been implemented. During the inspection, we visited six people in their own homes who were prescribed medicines that were administered by Comfort Call staff.

We found concerns regarding the safe handling of medicines for all these people. We found that records could still not be relied on to demonstrate that people had been given their medicines as prescribed for

them. We found that information about medicines in people's care plans were incomplete and did not explain how staff should handle people's medicines safely. Information recorded in people's care files regarding their ability to look after their own medicines was confusing and contradictory.

We also found there was no information as to who was responsible for ordering medicines. One person's records showed that the medication was 'finished' after 23 days, when only 21 days have been supplied, which indicated that their medication lasted two more days than it should have indicating medication had not been given each day.

Within care files, we found medication assessments had a space to be filled in if medicines were 'time critical.' We saw people prescribed medication that must be given at specific times, but there was no information which medicines should be administered at specific times. We saw people were not given these medicines at the correct times.

When people were prescribed medicines to be taken 'when required,' there was no information recorded to help staff decide when the medicines were needed.

During our visits we saw four people were prescribed Warfarin. This is a medication which required special monitoring to ensure that their blood is not too thick, placing them at risk of a stroke or too thin, placing them at risk of bleeding. We looked at Warfarin records for two people and saw they were either not given at the correct time or had not been given properly. Two other people had been given the wrong doses of Warfarin.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. CQC are currently considering their enforcement options in relation to the continued failure to meet the requirement of regulations in respect of the safe management of medication.

Both prior to the inspection and during this process we received information as a result of safeguarding referrals and complaints from relatives of people who used the service regarding consistently late or missed calls. The service was able to confirm from their own records that since February 2016 they had reported 10 missed calls. We found from speaking to people and from records supplied by the service that visits were often late and that staff often failed to undertake the full duration of the call. This was particularly noticeable for 15 minute calls, such as bedtime and medication, where staff were present for significantly less than the 15 minutes the service was being paid for.

We found that the service had insufficient numbers of staff deployed to ensure visits were undertaken effectively and within reasonable time scales.

We found repeated examples of when staff were significantly late for calls. We also noted that duration times, especially for 15 minutes calls were regularly of a shorter duration. We found that staff were sometime allocated two calls at the same time, meaning one call would be definitely late. We saw examples where travelling times between call had not been taken into consideration, meaning staff would always be late as a result.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing. This was because the service failed to deploy sufficient numbers of staff to ensure visits were undertaken effectively within reasonable time scales. CQC are currently considering their

enforcement options in relation to this matter.

We reviewed data provided by service, which included staff rotas and time sheets and found repeated examples of late calls being undertaken by staff. We saw examples of where staff had been allocated three or two calls at the same time, which meant calls were being scheduled in the knowledge they would be late. We noted that from the allocation of these calls, staff would invariably be rushing to meet scheduled times, which clearly impacted on the duration of time they spent with people who used the service.

Whilst the management team were very transparent and open about the current difficulties they faced as a service, we found no evidence that the provider had implemented any effective systems to assess, monitor and improve the quality and safety of the services provided in relation to the administration of medication and the scheduling of calls, given the concerns we found. The service was able to provide management data, which we were shown regarding scheduling, staff rotas, times and duration of calls. However, we saw no evidence that this data had been analysed to address the concerns we had identified.

We saw examples were individual members of staff were repeatedly late for calls and were not undertaking the full duration of the call. We found no evidence that the service had actively identified these concerns or taken any action with the individual member of staff to ensure calls were undertaken in a timelier manner.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance. The service had failed to implement systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. CQC are currently considering their enforcement options in relation to this matter.

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

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The service had failed to protect people against the risks associated with the safe management of medication.

Both prior to the inspection and during this process we received information as a result of safeguarding referrals and complaints from relatives of people who used the service regarding consistently late or missed calls.

We found that the service had insufficient numbers of staff deployed to ensure visits were undertaken effectively and within reasonable time scales.

Is the service well-led?

Inadequate

The service was not well-led. We spoke to the management team regarding the effective management of calls and from their own records were able to confirm that since February 2016, they had reported 10 missed calls.

We saw examples of where staff had been allocated three and two calls at the same time, which meant that calls were being scheduled in the knowledge they would be late.

The service had failed to implement systems to assess, monitor and improve the quality and safety of the services provided.

Comfort Call (Salford)

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.

We undertook an unannounced focused inspection at Comfort Call (Salford) on the 11 and 13 April 2016. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 16 December 2015.

We inspected the service against two of the five questions we ask about services during an inspection, which were not meeting legal requirements. These were specifically; 'Is the service Safe' and 'Is the service well-led.'

The inspection was undertaken by one adult social care inspector and a CQC pharmacist. Before the inspection, we reviewed all the information we held about the service, including concerns that we had received. We reviewed statutory notifications and safeguarding referrals. We also spoke with several relatives of people who used the service, who had raised concerns about the quality of services delivered.

We also reviewed the action taken by the provider following our previous inspection, who wrote to us explaining what action the service had taken to meet legal requirements.

At the time of our inspection there were 511 people living in the Salford area that used the service. We were told that 307 people utilised the domiciliary care services the company provided where staff attended people's own home to provide personal care. The service also operated four extra care housing schemes, which was used by 204 people. Each scheme was run by an extra care scheme manager and provided staff 24 hours a day on the premises.

Inadequate

Is the service safe?

Our findings

At the last inspection, in December 2015, we found that medicines were not handled safely and we told the provider they must take action to improve the safe handling of medicines. We visited the service on 11 and 13 April 2016 to ensure that improvements had been implemented. As part of the inspection, we visited the office of Comfort Call (Salford) and asked the manager to provide details of people who were currently prescribed medicines, which Comfort Call staff were responsible for administering.

We visited four people and additionally identified two other people who were prescribed medicines that were given by Comfort Call staff, who we also visited. We looked at medicines and records about medicines for all six people we visited. We also looked at how one of the extra care housing schemes handled medicines for people who lived there.

We found concerns regarding the safe handling of medicines for all these people. At the last inspection we found the records about the administration of medicines were poor, because there were repeated omissions/ signature gaps on the Medication Administration Record Sheets (MARS). After the last inspection the provider sent us an action plan outlining how they would improve medicine handling including how they would improve records keeping. We found no improvements had been made. At this inspection we saw that there were still numerous signature omissions of the MARS for all six people who used the service. This meant the records could still not be relied on to demonstrate that people had been given their medicines as prescribed for them.

We found that information about medicines in people's care plans were incomplete and did not explain how staff should handle people's medicines safely. The information in care files was simply duplicated from the local authority's support plans .We found either there was no list of medication or the medicines listed by the local authority were not exactly the same as people were currently taking. Lists of medication were either missing or not up to date, which meant the service could not check that people were being given the correct medicines.

The information recorded in people's care files regarding their ability to look after their own medicines was confusing and contradictory. Each of the six people whose records were looked at had a form in place that stated they needed 'level three support,' which signified 'compete support.' This was because they were 'unable to understand the medication they were prescribed.' Each person was also assessed as needing 'level two support,' which was defined as needing 'physical support under the person's direction.' Each person was also assessed as needing 'level one support,' which was defined as 'an occasional reminder.' This information failed to guide staff as to the level of support people required and how the staff should help people manage their medicines safely.

Medication risk assessments stated people needed 'supervision' to take their medicines. We asked the branch manager, regional manager and the person who delivered medication training to explain to us what the term 'supervision' meant. This was because the term was not defined in the medication policy. We were not given an exact explanation of the term, but there was an implication that staff would just 'watch over'

someone taking their medicines. However, when we visited one person who had their medication 'supervised,' we found staff were administering all their tablets. The person who used the service confirmed to us they had no idea where staff kept their tablets and could not take them by themselves. We saw on one day this person did not have their medicines, as records stated it had been 'mislaid.'

We also found there was no information as to who was responsible for ordering medicines. There was no record of the receipt of medication made by staff. Most people had their medicines delivered each week by the Pharmacy, but we saw that in some instances there was no information recorded to tell staff, which day the medication should arrive or what day of the week the new Dosette should be started on. 'Dosette' is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the person's home. The pack has a peel off plastic lid and lists the contents and the time the medication should be administered. We saw that one person was unable to have their medicines for at least one day in February and March 2016, because none had been delivered.

One person's records showed that the medication was 'finished' after 23 days, when only 21 days have been supplied, which indicated that their medication lasted two more days than it should have indicating medication had not been given each day. We looked at the medication pack for another person and found that staff had taken medication from the wrong day of the week, which lead to confusion. This meant it was difficult to tell if staff had given the correct medication on the correct day. This demonstrated that systems for handing people's medicines in their own homes were not safe and people were at risk.

The medication assessment had a space to be filled in if medicines were 'time critical.' We saw people prescribed medication that must be given at specific times, but there was no information which medicines should be administered at specific times. We saw people were not given these medicines at the correct times. If medicines are not administered according to times specified they may not work properly or they may be given at an unsafe time interval.

The medication policy stated clearly that staff must not purchase any over the counter medication for people unless they have checked with the person's GP. We saw that care staff had purchased some antacids tablets for one person. No record had been made that they had checked with the GP that it was safe for these tablets to be taken with their prescribed medication. We saw that two of their prescribed medicines should not be taken at the same time as antacids as it could reduce the effectiveness of their prescribed tablets.

We saw when people were prescribed medicines to be taken 'when required,' there was no information recorded to help staff decide when the medicines were needed. This meant people were at risk of not being given medicines when they needed them.

We visited another person, who suffered with short term memory loss. Records demonstrated that they did not always take their Paracetamol, which was given to them with the other tablets from a blister pack. There was no record as to how or where the Paracetamol were disposed of. The person told us, "I think I may throw them away." The member of staff could not confirm where the unwanted tablets were. We also saw when this person took the Paracetamol regularly the time between doses was not safe, because they were not given with a safe four hour gap.

We visited one person who was living with dementia. We spoke with her family who were visiting. They told us they sometimes found tablets on the floor, which had not been taken. They found that staff signed they had applied creams to their relative, but the cream had not been applied. They also told us that staff refused to apply a barrier cream when they had seen to their personal care. We saw this person was prescribed

inhalers, but the family said the service had told them they were not to give them as it was not part of their 'remit,' which was in contravention of the service medication policy.

One person, who had their medication administered by staff, was prescribed a morphine based tablet. We saw that on some days the records for this tablet were marked 'S' indicating that the person administered the tablet themselves, while on other days there were gaps on the records. This meant it was impossible to tell if they had been given pain relief as prescribed.

During our visits we saw four people were prescribed Warfarin. This is a medication which requires special monitoring to ensure that their blood is not too thick, placing them at risk of a stroke or too thin, placing them at risk of bleeding. We looked at Warfarin records for two people and saw they were either not given at the correct time or had not been given properly. Two other people had been given the wrong doses of Warfarin. This meant people's health was placed at significant risk of harm, because incorrect doses of a vital medication were given.

During the inspection we saw the times of people's calls were not always recorded in the care plan and there was no information to confirm that people were happy with the times of the calls. One relative told us they were unhappy with the call times and we saw that another person was not given Paracetamol safely, because the times between calls had not been considered carefully. We saw people were not given their time crucial medicines at the correct times, because the medication had not been identified as 'time critical.' We also received information that one person who suffered from diabetes and Parkinson's did not have their medication at the correct times, because calls were late or missed. This placed this person at significant risk of harm, because they were not given their medication as prescribed at the times it was needed.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. CQC are currently considering their enforcement options in relation to the continued failure to meet the requirement of regulations in respect of the safe management of medication.

Both prior to the inspection and during this process we received information as a result of safeguarding referrals and complaints from relatives of people who used the service regarding consistently late or missed calls. The service was able to confirm from their own records that since February 2016 they had reported 10 missed calls. We found from speaking to people and from records supplied by the service that visits were often late and that staff often failed to undertake the full duration of the call. This was particularly noticeable for 15 minute calls, such as bedtime and medication, where staff were present for significantly less than the 15 minutes the service was being paid for.

We found that the service had insufficient numbers of staff deployed to ensure visits were undertaken effectively and within reasonable time scales.

One relative of a person who used the service told us that they had agreed with the service that they would receive the calls at the following times; morning 8.30am; lunchtime 12.45pm; teatime 5pm and bedtime 8pm. It was also stressed to the service the importance of timings due to their relative's need to take medication with food in accordance with their consultant's instructions. They reported repeated late calls with no communication or notification from the service. Examples included staff being late for the morning call of 8.30am and turning up 11.10am. This meant the person who used the service had not had their medication, which had been due at 9.00am with their food.

On another occasion, we were told the relative received a call from their loved one that staff were late. They eventually received their breakfast at 11.50 am, with the medication having being delayed. The relative told us their loved one had not eaten since 16.15pm on the previous day as that was the time of their 'teatime' call, therefore they had not eaten for 19hrs. On another occasion staff did not attend a lunchtime visit. When they contacted the service, they were told the agency was unaware that staff had not attended.

On other occasions staff had not attended for bedtime visit. When the service were contacted they told the relative they were short staffed and were unsure, which member of staff would be attending. A member of staff eventually arrived 1 hour late.

We spoke to the regional manager about late calls who explained there was an agreed 30 minute window on either side of the agreed call time. Relatives we spoke with said they were unaware of this 30 minute window on either side of the call, but understood that the service could not always be punctual. People felt that staffing was a serious concern with staff attending significantly late, early or not at all.

Another relative told us that they did not believe staff had a full understanding of the importance of their relative having their medication at set times or the impact if not given at these times. Staff attended at various times, which did not correspond with when their medication should be given.

One relative we spoke to during a visit told us; "It's started to be a regular thing that they are late." They also told us that they had noticed staff undertaking short calls such as seven minutes, when 15 minutes had been allocated. Other comments from relatives included, "Sometimes late or early and inconsistent." "Couple of times late visits. Very late at times 35 – 40minutes late, the wife gets very agitated." "Yesterday the carers didn't turn up at all for the evening visit and I was given no warning that this was going to happen. After ringing Comfort Call about this all they had to say in a very nonchalant and dismissive way was sorry 'we messed up' and put the evening visit in for today instead of yesterday by accident."

The manager told us that calls were currently monitored in the office between 8am – 4pm. Staff would make a free phone call on arrival at someone's home and when they departed. Providing staff were able to do this, a record was made of the time of arrival and departure and included the duration of the visit. We asked to see a sample of this data including staff rotas and visits allocated.

We found repeated examples of when staff were significantly late for calls. We also noted that duration times, especially for 15 minutes calls were regularly of a shorter duration. We found that staff were sometime allocated two calls at the same time, meaning one call would be definitely late. We saw examples where travelling times between call had not been taken into consideration, meaning staff would always be late as a result.

One member of staff told us that they were regularly scheduled three calls at the same time and that travelling time between calls was not factored in.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing. This was because the service failed to deploy sufficient numbers of staff to ensure visits were undertaken effectively within reasonable time scales. CQC are currently considering their enforcement options in relation to this matter.

Inadequate

Is the service well-led?

Our findings

Both prior to the inspection and during this process we received information as a result of safeguarding referrals and complaints from relatives of people who used the service regarding consistently late or missed calls. The management team confirmed from their own records that there had been at least 10 missed calls since February 2016.

We reviewed data provided by the service, which included staff rotas and time sheets and found repeated examples of late calls being undertaken by staff. We saw examples of where staff had been allocated three or two calls at the same time, which meant that calls were being scheduled in the knowledge they would be late. We noted from the allocation of these calls, staff would invariably be rushing to meet scheduled times, which clearly impacted on the duration of time they spent with people who used the service.

Whilst the management team were very transparent and open about the current difficulties they faced as a service, we found no evidence that the provider had implemented any effective systems to assess, monitor and improve the quality and safety of the services provided in relation to the administration of medication and the scheduling of calls, given the concerns we found. The service was able to provide management data, which we were shown regarding scheduling, staff rotas, times and duration of calls. However, we saw no evidence that this data had been analysed to address the concerns we had identified.

We saw repeated examples of where staff had been allocated more than one call at the same time and no allowance had been made for travelling between calls. We saw examples were individual members of staff were repeatedly late for calls and were not undertaking the full duration of the call. We found no evidence that the service had actively identified these concerns or taken any action with the individual member of staff to ensure calls were undertaken in a timelier manner.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance. The service had failed to implement systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. CQC are currently considering their enforcement options in relation to this matter.

We spoke to the new manager, who had recently been appointed by the provider. They acknowledged the scale of the concerns and assured us they were determined to improve the service for the benefit of people who used their services. They explained that a new calls monitoring system was being implemented, which meant staff would be able to have they calls monitored more accurately. Each member of staff would be provided with a mobile phone, which they would use to scan a 'chip' located in each person's care plan or arrival and departure at people's homes. Calls would be actively monitored by the service between 7am and 10pm. We were told that if a member of staff failed to scan the 'chip,' an alert would be sent to the office, which would remain active until the person monitoring the system had actioned and recorded the reason for the late / missed call. We were told that all calls would be placed as time critical and alerts would be set for staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service had not protected people against the risks associated with the safe management of medication.

The enforcement action we took:

To be compliant by 01 August 2016

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

To be compliant by 01 August 2016

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to deploy sufficient numbers of staff to ensure visits were undertaken effectively within reasonable time scales.

The enforcement action we took:

To be compliant by 01 August 2016